

SESSION 2 - SAFETY

EMERGENCY PREPAREDNESS

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THE CERN STAFF AS INTERFACE OF THE EMERGENCY MANAGEMENT PROCESS ... and often it is at the interfaces that the risks come to surface

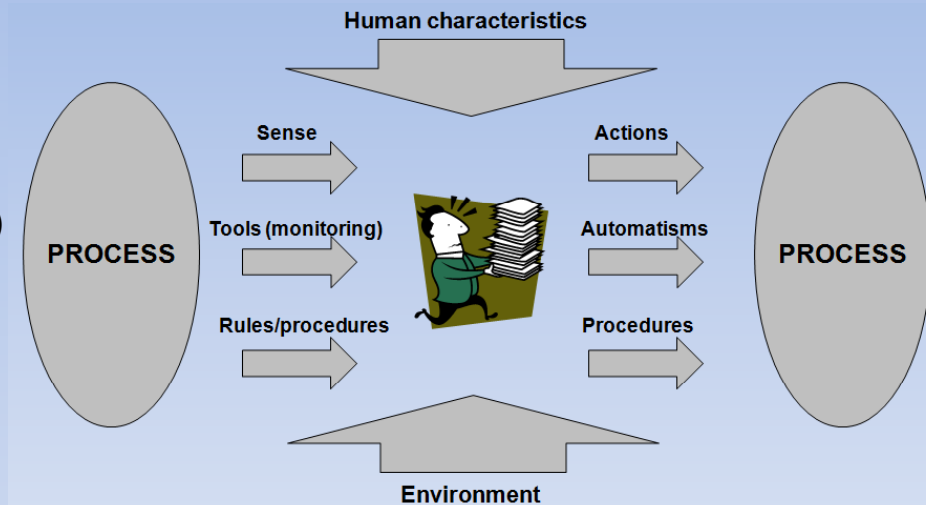


Human characteristics

- Difficulties to assess the risk and the seriousness during an abnormal event
The more an event is serious, complex, unknown, non-recurrent, the more the information given to the operator shall be formalised, simple and clear
- Different type of errors
 - Perception errors
 - Decoding errors
 - Operating mode/instruction not respected (deliberately or not)
 - Missing decision in due time
 - Wrong sequence in the actions performed
- Overconfidence bias effect
- Anticipative/Adaptative abilities

Risks at the (Wo)men – process interfaces

- Risks related to the information received from a process
 - ✓ Design of the tools (monitoring)
 - ✓ Pertinence of displayed parameters
- Risks related to the intervention/actions from operators to a process
 - ✓ Is the relation between the action and the expected effect clear enough?
 - ✓ How are managed the different sequences of actions (implicit, explicit procedures, habits ...)?
- Communication between people
 - ✓ Correct wording (meaning)
 - ✓ Different languages



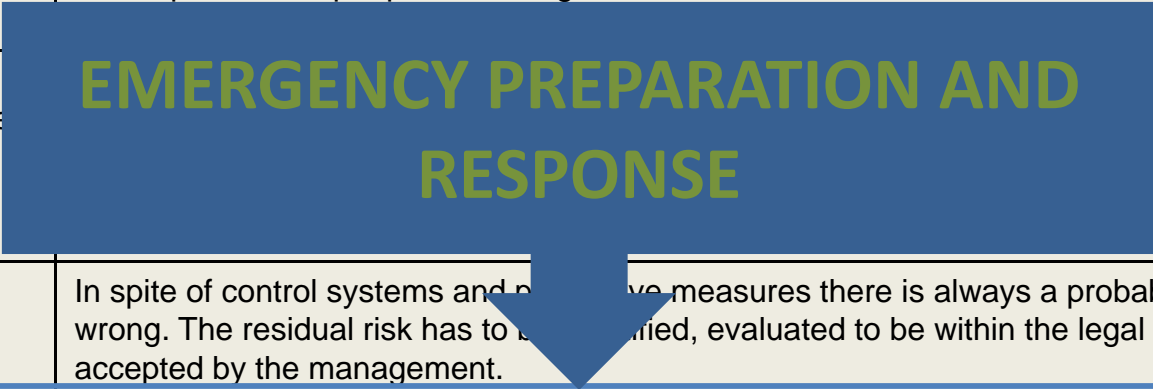


Situations	NORMAL	INCIDENT	ACCIDENT	ACCIDENT <small>Requiring external assistance</small>	MAJOR ACCIDENT	CRISIS
	<p>NORMAL OPERATION</p> <ul style="list-style-type: none"> - Situation under control - Limited and « short » downtimes 		<p>EMERGENCY MANAGEMENT</p> <ul style="list-style-type: none"> - Unexpected and unknown situations, threat for people, environment, equipment - Operation interrupted, long downtimes 			
	<p>Continuous risk assessment</p> <p>Preventive/protective improvements</p> <p>Reviews (audits)</p> <p>Safety procedures/instructions</p> <p>Safety training</p> <p>Equipment and system maintenance</p> <p>Equipment and system test</p> <p>Equipment and system monitoring</p> <p>Management of technical alarms</p> <p>...</p> <p style="text-align: center;">Risk Management</p>		<div data-bbox="1003 392 2002 938" style="border: 1px solid gray; padding: 10px;"> <p style="text-align: right; font-size: small;">From HB 221 / ISO/IWA</p> </div> <p>A serious incident/accident/crisis includes three different processes:</p> <ul style="list-style-type: none"> ✓ Emergency response ✓ Continuity ✓ Recovery <p>Each must be planned and organised in advance in the emergency preparedness process.</p> <p style="text-align: center;">Risk Control</p>			

THE 8 STEPS OF THE EMERGENCY MANAGEMENT PROCESS



1	Threats / Hazard	Generic identification of natural, technical or human caused issues that might cause the organization to fail relative to the given objectives
2	Risk assessment - Probability - Impact/ Consequences	Risk assessment is the overall process of risk identification, risk analysis and risk evaluation. The identified threats / hazards become risks when they have a certain probability and measurable consequences on people or the organization.
3	Prevention Define preventive measures	measures in order to valves, periodical preventive measures are iterative evaluation
4	Residual risk acceptance	In spite of control systems and preventive measures there is always a probability that things go wrong. The residual risk has to be identified, evaluated to be within the legal boundaries and to be accepted by the management.
5	Preparedness	Emergency preparedness and incident response has to cover the residual risk. These measures have to be organized, planned and trained before the emergency occurs. Typical example are not only the preparedness of Fire Brigade and Medical Service, but also is there a high importance of the departmental emergency plans coping with the risks identified in 2,3 and 4.
6	Emergency response mitigation of effects	In this step an incident / emergency has occurred and the situation needs to be brought under control by emergency services. This is done with organization schemes according to the level of seriousness e.g. as described in IS 51.
7	Continuity	Continuity is the capability of an organization to operate under exceptional circumstances and situations in order to continue operations at an acceptable minimum level. e.g. continuity of safety systems, power supply, cooling and ventilation, access system.
8	Recovery	Recovery is the reinstallation of normal operation conditions of the organization. A fully fledged emergency management system sets levels (finance, manpower, delivery time) within which it is expected to recover completely.



1. THREATS – CERN'S LEVELS OF SERIOUSNESS



Situations	NORMAL		INCIDENT		ACCIDENT		ACCIDENT Requiring external assistance	MAJOR ACCIDENT	CRISIS	
Safety Alarm levels	ALO	AL1	AL2	AL3		AL3				
Management	Internal					Internal + External				
Levels of seriousness (IS51)	<p>LEVEL 0 Level 0-1: Accidents with negligible injuries or damage which are usually rapidly settled locally. Level 0-2: Minor accidents with injuries or small and limited damage and/or pollution, which can be easily mastered and that only concern the territory of the Organization. Level 0-3: Accidents, fires or environmental hazards with injured person(s) and/or damage which can be mastered by CERN with limited need for coordination by CERN specialists or groups and/or singular outside assistance</p>					<p>LEVEL 1 Serious accidents with major injuries or damage or which require long term or high risk intervention of the CERN Fire Brigade or need for coordination by CERN specialists or groups as well as outside assistance. Accidents, where an impact on CERN's surroundings cannot be excluded</p>		<p>LEVEL 2 Major accidents with an important impact on the site of the Organization and surroundings. Major accidents outside CERN with threats to CERN areas or installations or extended need of coordination and extended support of Host States' emergency services</p>		
						LHC Sector 3-4				
Conventional accident worst case(*)						Release of cryogenic fluids in the tunnel during <i>shutdown</i>				
Chemical accident worst case(*)						Accidental release of cyanhydric acid following a chemical reaction				
Radiological accident worst cases(*)						Fire in the collimator area in Point 7 of the LHC tunnel during beam operation Fire in radioactive elements storage area (i.e. Bld. 607) with radiological consequences Fire on filters at CNGS air extraction outlets				
Radiological impact (INES scale)	0 – « Ecart »	1 – Anomaly	2 – Incident	3 – Serious incident	4 – Accident with local consequences		5 – Accident with wider consequences	6 – Serious accident N/A	7 – Major accident N/A	

* As defined in the document (Plan d'Urgence Interne) PUI sent to the Host States Safety Authorities

1. THREATS – Sector 3-4 event's levels of seriousness



Situation accidentelle relevant d'un PUI conventionnel

Fiche de l'événement redouté

Rejet des fluides cryogéniques en souterrain pendant la période de <i>shutdown</i>	
Local	tunnel LHC
Nature de l'accident	rupture d'une ligne d'hélium liquide
Détection	détecteurs « manque oxygène »
Conséquences	danger d'asphyxie et de brûlure pour le personnel
Matériel de protection	masques à oxygène obligatoires dans le tunnel
Mesures préparatoires d'intervention	procédure d'intervention du SSF

Dans le tunnel LHC (machine), les défaillances suivantes peuvent avoir comme conséquence un rejet massif d'hélium en présence de personnes :

- Rupture d'une ligne d'hélium liquide incorporée dans la ligne de distribution cryogénique séparée (QRL) avec un rejet massif d'hélium liquide dans l'enceinte à vide, augmentation de la pression dans celle-ci, ouverture des vannes de sécurité et rejet d'hélium (froid). Débit maximum d'hélium: 2 kg/s ; quantité maximum d'hélium rejeté: 3300 kg.
- Rupture d'un élément dans la connexion entre la ligne de distribution (QRL) et la chaîne des aimants avec rejet d'hélium. Débit maximum d'hélium : 20 kg/s ; quantité maximum d'hélium rejeté: 4250 kg.
- Rupture d'un élément dans une boîte froide (QRLA) avec rejet d'hélium dans le puits et/ou dans une caverne souterraine. Débit maximum d'hélium : <2 kg/s ; quantité maximum d'hélium rejeté: 180 kg.

* As defined in the document *Plan d'Urgence Interne - PUI*

On 19 September 2008, during powering tests of the main dipole circuit in Sector 3-4 of the LHC, a fault occurred in the electrical bus connection in the region between a dipole and a quadrupole, resulting in mechanical damage and release of helium from the magnet cold mass into the tunnel.

The spring-loaded relief discs on the vacuum enclosure opened when the pressure exceeded atmospheric, thus releasing helium into the tunnel, but they were unable to contain the pressure rise below the nominal 0.15 MPa in the vacuum enclosure of the central subsector, thus resulting in large pressure forces acting on the vacuum barriers separating the central subsector from the neighbouring subsectors.

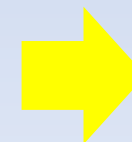
** Report on 080919 incident at LHC (DG)



CONVENTIONAL



On 19 September 2012?



RADIOLOGICAL

2. RISK ASSESSMENT



➤ SPS/CNGS and LHC operation's risk assessment

- ✓ "INB" reports can be considered as the SPS/CNGS and LHC operation's Safety files – RPS I.7 (EDMS 634769)

Sector 3-4 event ➡ **RPS I.7 needs to be updated!!!**

- ✓ Safety studies performed during the design phase of LHC
Access Safety System
Beam Dump System
Machine Protection System
etc...

Sector 3-4 event ➡ **Safety Design Criteria at the interfaces?**

- ✓ Simulation, prototyping feedback

Sector 3-4 event ➡ **Functional Safety oriented?**

➤ Lessons learned from past experience with incident/accidents

- ✓ Logging, reporting and analysis

Sector 3-4 event ➡ **Fact finding data/information available? Shared?**

➤ Risk assessment (Safety files) for other existing and new facilities?

- ✓ LHC Experiments' Safety files
- ✓ Primary Beam areas (Linac, Booster, PS, AD, nToF, etc)
- ✓ Secondary Beam areas (PS, SPS Experimental Areas)

Centralised management of all Safety files with relevant information and eventually improvement programs!

◆ **Consequence categories:**

Category	Injury to personnel		Damage to equipment	
	Criteria	N. fatalities (indicative)	SwFr Loss	Downtime
Catastrophic	Events capable of resulting in multiple fatalities	≥ 1	> 5*10 ⁷	> 6 months
Major	Events capable of resulting in a fatality	0.1 (or 1 over 10 accidents)	10 ⁶ – 5*10 ⁷	20 days to 6 months
Severe	Events which may lead to serious, but not fatal, injury	0.01 (or 1 over 100 accidents)	10 ⁵ – 10 ⁶	3 to 20 days
Minor	Events which may lead to minor injuries	0.001 (or 1 over 1000 accidents)	0 – 10 ⁵	< 3 days

11/10/2001

F. Balda - AIWG n. 35

3. PREVENTION



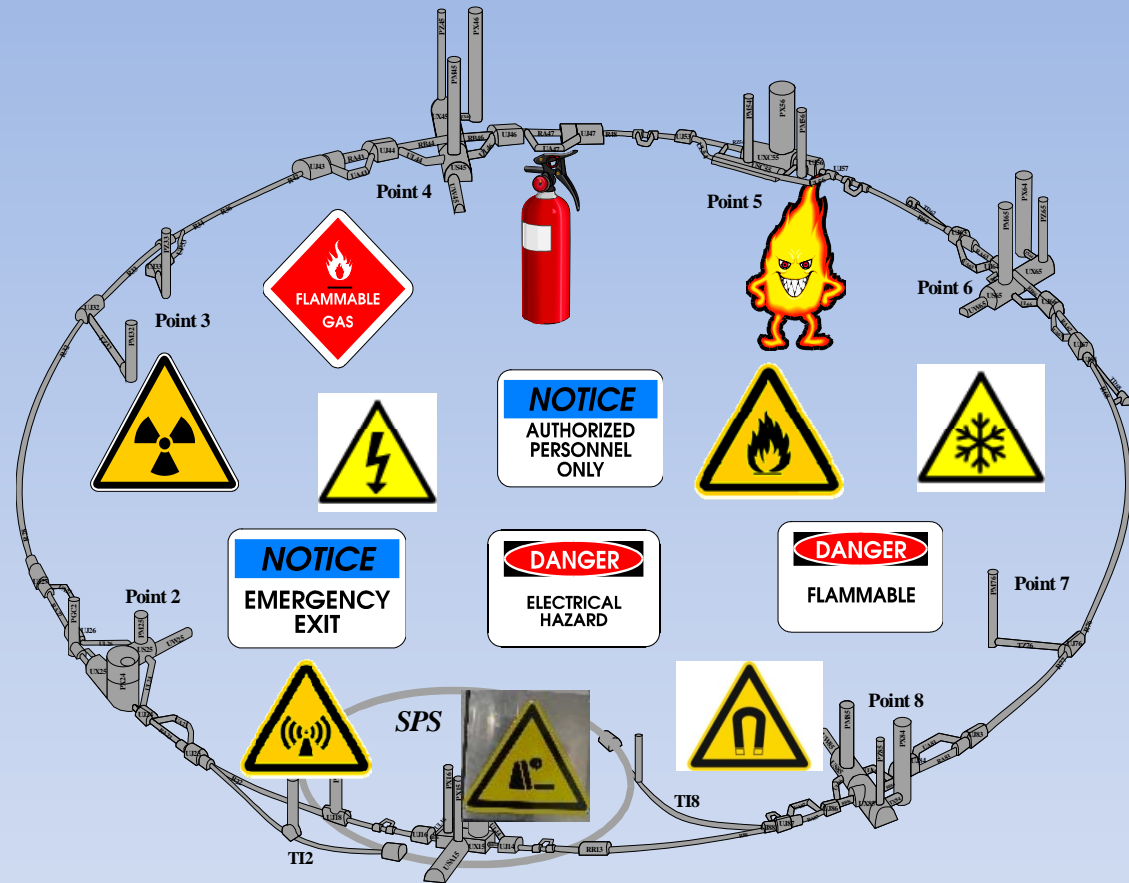
➤ PERSONNEL PROTECTION SYSTEMS

- Access Safety Systems
- Access Control Systems
- Fire Detection Systems
- Flammable Gas Detection Systems
- ODH Detection System
- Emergency Evacuation System
- Flooding Detection Systems
- General Emergency Stops Systems
- Level 3 Alarms Transmission Systems
- Personnel Protection Devices
- Radiation Protection Monitoring
- Environmental Monitoring System

➤ MACHINE PROTECTION SYSTEM

➤ SENSITIVE EQUIPMENT AND SYSTEMS

➤ MONITORING/SURVEILLANCE



Sector 3-4 event



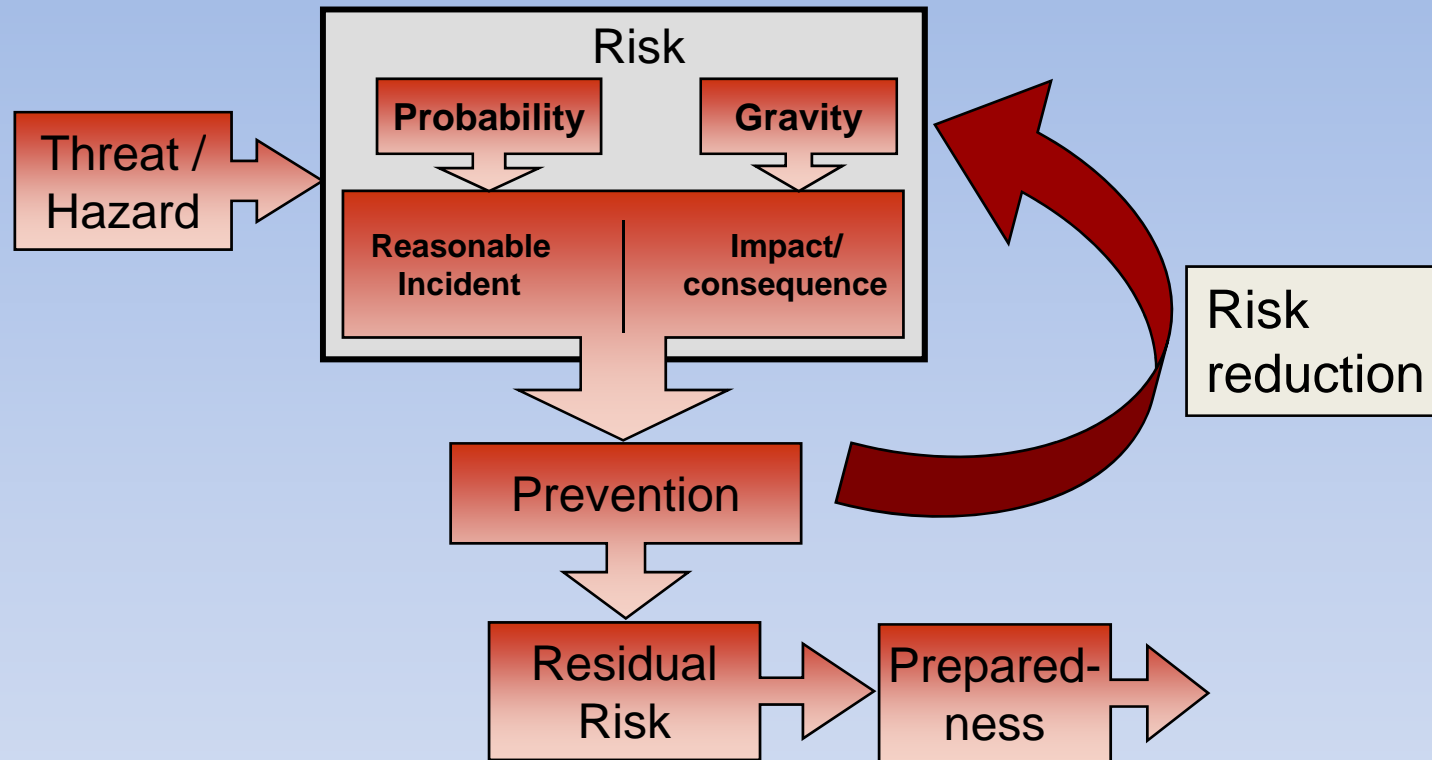
RELIABILITY
AVAILABILITY
MAINTAINABILITY
SAFETY

POLICY



Maintenance planning
Periodic tests
DSO tests
...

4. RESIDUAL RISK



- Risk reduction by an iterative process of risk analysis and prevention
- The residual risk has to be compared with legal boundaries and accepted by the management

Sector 3-4 event → ACCEPTABILITY → CONSOLIDATION?

5. PREPAREDNESS



Preparedness Organisation

- Level 2 Alarms monitoring and follow up
- Near misses analysis
- Procedures/instructions in case of incident/accident
- Education and training of all players (Management, departments, control rooms, emergency services)
- Full exercises as well as table top exercises
- Appropriate Equipment for intervention and Command & Control

Emergency Preparedness documentation

- Documentation/procedures/operating modes (*"Perfection is not when there is nothing more to add but when there is nothing more to remove"?*)
 - ✓ In line with the rules and regulations in force
 - ✓ Clear responsibilities
 - ✓ Available where needed
 - ✓ Adapted to the circumstances (from normal situation up to crisis situation)
 - ✓ Simple wording
 - ✓ Pictograms
 - ✓ Documentation Management System
 - ✓ Harmonised templates
 - ✓ Grows in effectiveness and efficiency by real life experience and exercises

Information during Emergency management

- Provide only useful, exact, pertinent, simple and unambiguous information to all stakeholders

5. PREPAREDNESS DOCUMENTATION STRUCTURE



Safety Documentation Structure (Recommended)

Situations	NORMAL	INCIDENT	ACCIDENT	ACCIDENT <small>Requiring external assistance</small>	MAJOR ACCIDENT	CRISIS
Documents Plans (required)	Safety Documents/Plans		Internal Emergency Plan	External Emergency Plan		
			Recovery Plan			
	Risk Management		Risk Control			

CERN Safety Documentation Structure (January 2009)

CERN Safety Rules	Adapted? Applicable? Valid?				
CERN	Departmental Safety Plans	Plan d'Urgence Interne	« Héphaïstos » Project		
SPS/CNGS/LHC operation	Règles de sécurité à l'ATLAS	Under revision	In work		
LHC experiments	Predefined incident response procedures ATLAS	Fire Brigade procedures/training/exercises ✓			
CPS Exp. areas	Security procedures				
LHC experiments	Safety procedures/instruction/organisation	CERN Recovery Plan		?	

Only paper?
Applicable?
Up to date?
Coherent?
Shared?
Managed?

6. EMERGENCY RESPONSE AND MITIGATION



Situations	NORMAL		INCIDENT		ACCIDENT	ACCIDENT Requiring external assistance	MAJOR ACCIDENT	CRISIS	
Management	Internal					Internal + External			
Safety Alarm levels	AL0	AL1	AL2	AL3		AL3			
Warning Safety alarm transmission	Monitoring systems warning responsables and/through the CCC		CSAM and/or phone call to SCR (74444) warning the CERN Fire Brigade		CSAM and/or phone call to SCR (74444) warning the CERN Fire Brigade Host States' services alerted/informed following the level of seriousness				
Intervention	Technical services On duty services		CERN Fire Brigade in collaboration with the technical services and/or on duty services		CERN Fire Brigade Swiss Fire Brigade (SIS GE) French Fire Brigade (SDIS 01)				
Levels of seriousness (IS51)	LEVEL 0				LEVEL 1		LEVEL 2		
Levels of seriousness (Host States' definition*)	A				A+	B1/B1 bis	B2		
Poste de commandement de l'intervention (PCI*)	PCI CERN				PCI CERN supported by PCI SIS GE or PCI SDIS 01		PCI SIS GE or PCI SDIS 01 supported by PCI CERN	PCI SIS GE and PCI SDIS 01 supported by PCI CERN	
Etat Major des Opération (EMO*)						EMO GE or/and EMO 01 eventually EMO leader designated		PCI SIS GE and PCI SDIS 01 supported by PCI CERN	
Cellule de Crise Stratégique (CCS*)						DG CERN Préfet or/and Conseiller GE		DG CERN Préfet/Conseiller GE Désignation de l'EMO leader	

* Hephaïstos project



- Identify equipment, supplies, and supply chain interactions that support the critical activities
- Develop strategies to secure operation of safety systems, maintenance and research facilities
- Re-establish critical operations already during incident response
- Maintain operations and services

Energy-Gas sector e.g.

Electrical power

Emergency power supply capacity

Emergency power distribution capacity

Gas, heating, hot water

Compressors

Helium, Argon, Nitrogen

Infrastructure sector e.g.

Access system availability

Safety system availability

Construction safety (Buildings, Installations)

Traffic circulation on CERN sites

Ventilation and cooling

Safe access to underground for maintenance

Information network

Human resources sector e.g.

Delay of CERN stand by services

Delay of contractors' services

Availability of CERN, users' and
contractors' specialists

Emergency epidemic plan



The recovery plan should identify and consider:

- An estimation about the time table for restoration of operation according to the identified main risks
- Identification of installations and operations that cannot be restored with reasonable delay
- Total or partial suspension of operations not urgently needed
- Decisions on keeping on stock a minimum number of critical spare parts
- Additional technical and human resources required from outside
- Co-operation agreements with partners to contribute to the recovery
- Procedures for financial consideration (insurances, provisions, stakeholders)
- Pre-emptive planning based on lessons learned

SUMMARY – MAIN POSSIBLE ACTIONS/IMPROVEMENTS

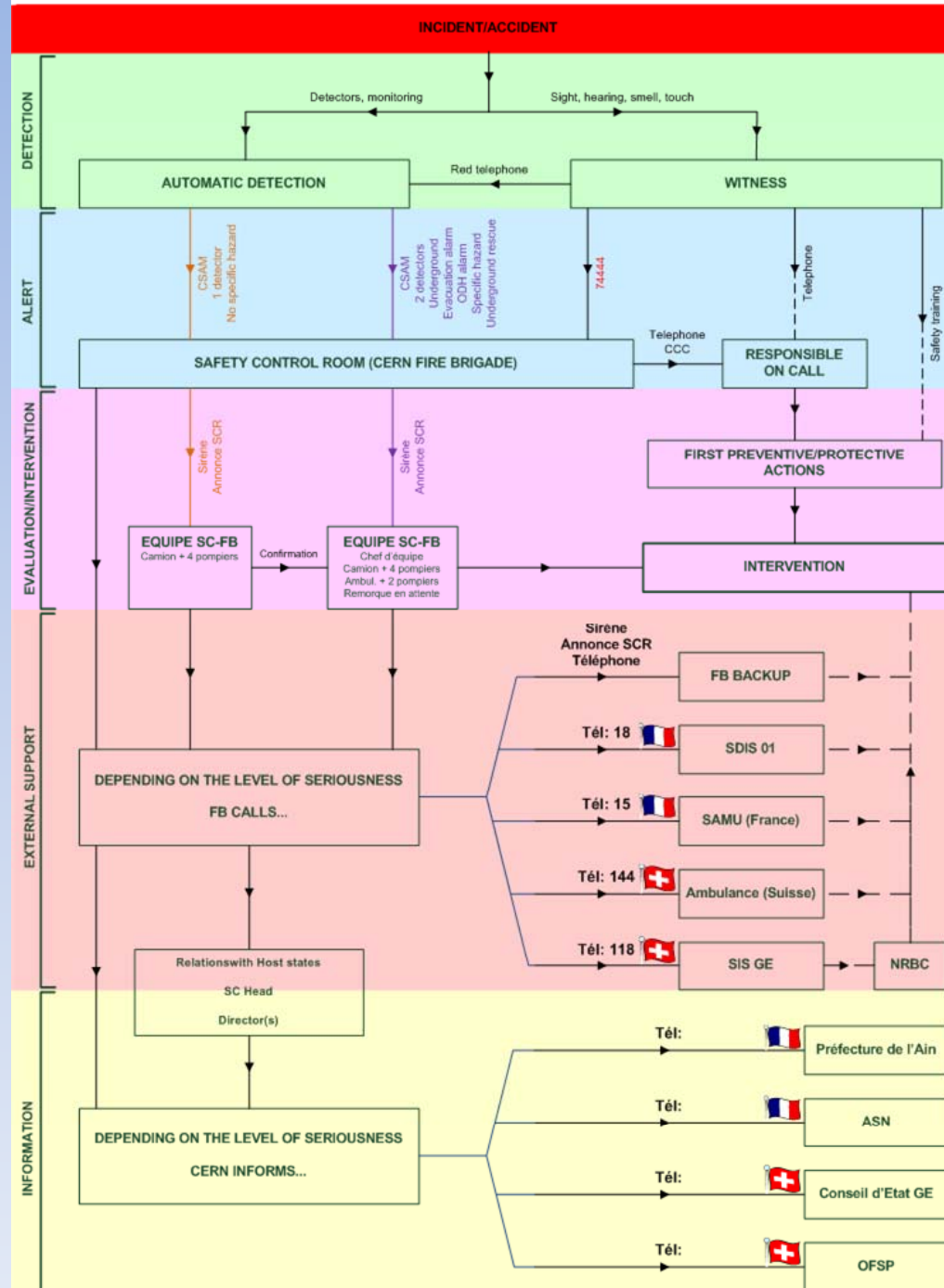


Sector 3-4 accident Sector 3-4 opportunity?

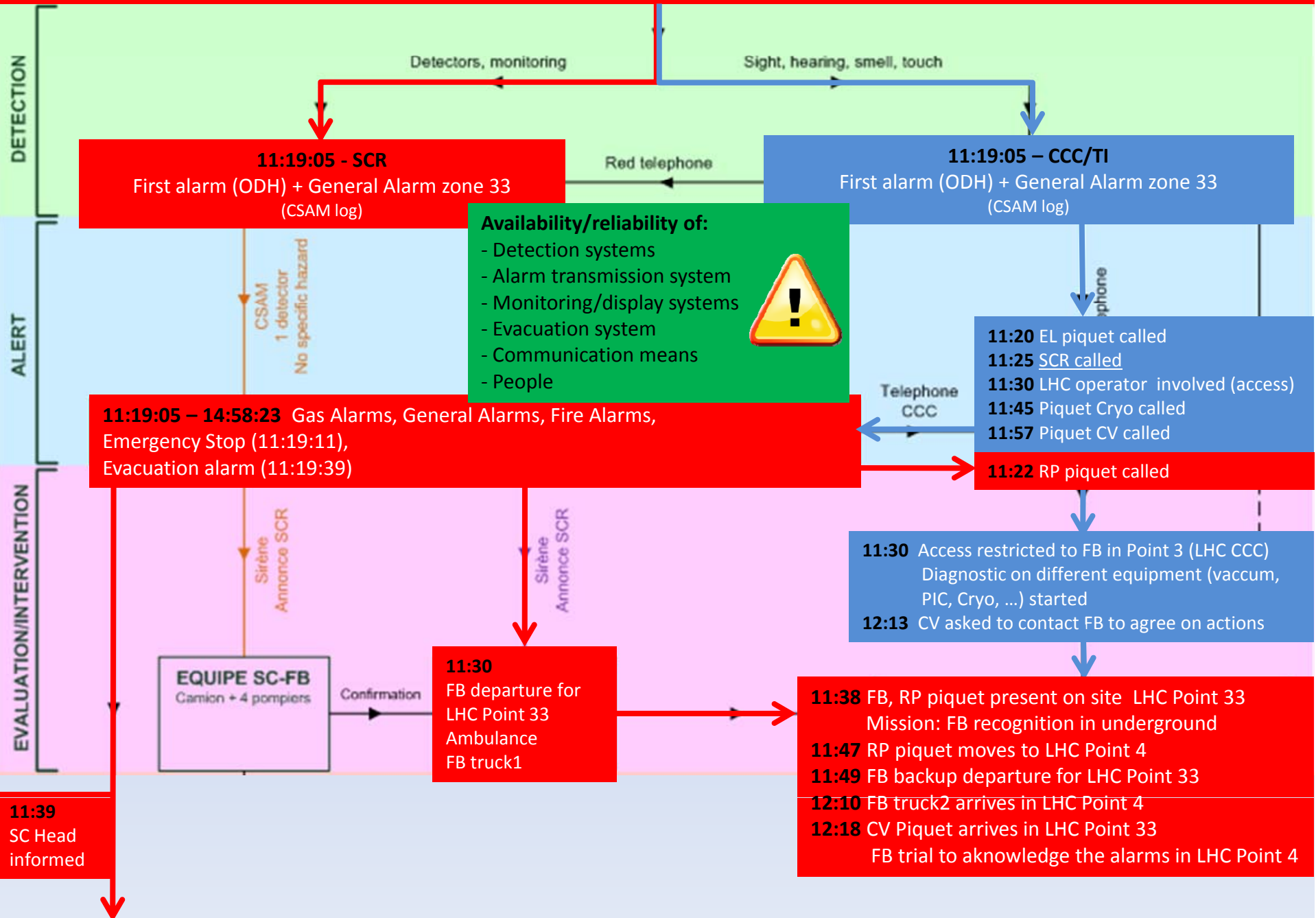
Threats / Hazard Identification	✓ exhaustive?	➤ Re-assess the risks of damage to equipment
Risk assessment - Probability - Impact/ Consequences	✓ incomplete?	<ul style="list-style-type: none"> ➤ Check the risk assessment at the interfaces ➤ Tackle the Safety File production process ➤ Elaborate a centralised accident logging and analysis tool ➤ Compare CERNs current situation on Emergency management with ISO 31000 and ISO PAS 22399
Prevention Define preventive measures	✓ availability/reliability to be assured	<ul style="list-style-type: none"> ➤ Define a list of critical/sensitive systems ➤ Implement a quality assurance plan for these systems ➤ Evaluate the residual risk impact also on downtimes
Residual risk acceptance	✓ awareness of the residual risk	<ul style="list-style-type: none"> ➤ Define the consequences related to the residual risk ➤ Search for potential improvements
Preparedness	✓ (Fire Brigade) ≈ Organisation/documentation	<ul style="list-style-type: none"> ➤ Review/clarify Safety Rules on Emergency Management ➤ Update Safety Plans/Procedures, Internal Emergency Plan ➤ Ask/help for the elaboration of an External Emergency Plan
Emergency response mitigation of effects	✓ external support?	<ul style="list-style-type: none"> ➤ Elaborate “modus operandi” with external Emergency services ➤ Perform regular training and exercises
Continuity	✓ immediate response	<ul style="list-style-type: none"> ➤ Define a Emergency Management Method ➤ Elaborate Continuity/Recovery Plans (guidelines)
Recovery	≈ framework	

CERN EMERGENCY WARNING OUTLINE

ec/alerts.vsd/Novembre2008



The first evidence was the appearance of a voltage of 300 mV detected in the circuit above the noise level: the time was **11:18:36 CEST** (*Report on 080919 incident at LHC - DG*)



SCR

12:37 FB recognition mission in LHC Point 33 aborted

12:46 FB intervention team moves to LHC Point 4

12:52 Info AT-CGR: No more leak

12:54 FB intervention team moves to LHC Point 4

Situation on the other LHC site?

- Information
- Instructions
- Evacuation



13:15 FB starts intervention in Point 4 underground
Mission: Collecting information: Oxygen Deficiency, Temperature, radiological situation, etc
FB support team and AT-CGR piquet in stand-by

13:32 FB intervention enters R39 tunnel

14:00 Crisis meeting with DG

14:09 FB intervention message: Temperature 20°, Oxygen 13% (1 km from IP4)

CCC

12:25 CCC informs SCR: Helium leak (~1 ton) at 19R3 up to 22R3 location

12:35 CCC informs SCR: location not fully identified, 6 magnets concerned

informs: location of the problem is between 6 and 7906

informs: L4 purge: air pulse in the direction

13:32 CV informs: FB asked for hottest air supply (presently 32°)

13:43 FB informs: progression in direction of Point 3

14:12 FB informs: Temperature 20°, Oxygen 13% (1 km from IP4)

SCR

14:20 FB intervention aborted due to lack of radio communication

15:20 FB intervention 1st toll:
Recognition up to 1600m from IP4
Frost-covered magnets
Air Temperature 5°
Dipoles temperature -20°
In RE42: 16% O₂, beyond: 11%
Visible Helium cloud
AT-CGR requested to give feedback on QRL
Ventilation air flow: 50'000 m³/h
PM32 pit (top): Helium present, T = 11°

16:00 New FB intervention with new communication means and instructions

16:35 Intervention request for TIM team. Agreed

16:44 FB intervention on going

17:10 FB intervention team informs: 1600m from Point 3: Temperature = 12°, O₂ = 18%, Dipole Temp = -16°

CCC

14:45 FB informs: intervention aborted, Temperature 20°, Oxygen 13% (1 km from IP4)

15:40 FB request received: information on tunnel vault pressure?

15:50 Civil Engineering called: information on tunnel vault pressure?

16:10 Civil Engineering informs: latest data 8.5 bar dated August 6th. FB informed

SCR

17:17 Civil Engineering request: verification of any tunnel vault collapse

17:49 FB intervention team informs: magnets moved from their position, ventilation door repaired

18:01 FB intervention in point 3 to control ventilation doors

18:34 All intervention aborted on Project Leader request

18:48 Head of SC confirms the abort instruction

18:58 FB deputy Head evacuation instruction to all FB intervention teams

19:04 All intervention teams exits via PZ45

CCC

18:00 Access instruction: No access in sector 3-4 except emergency

18:40 CV informs: they leave the site, ventilation left as it is (50'000 m³/h, Air temp = 32°)

19:30 FB informs: all interventions ended

