



### Key Themes

- Leadership
- Process Safety
- Safety Management Systems
- Human Factors
- The Safety Case

### Target Audience

Suitable for leaders and operational workforce across major hazard industries and legacy projects.

### Synopsis

On the 6th of July 1988, an inferno swept through the Piper Alpha platform in the North Sea, taking the lives of 167 men.

The AKT Piper Alpha safety workshop draws on the influential Cullen report and personal testimonies in the Scottish and National Archives, showing the reality of the impact.

Our dramatisation highlights the lack of proper oversight of production operations in the North Sea. We explore how disastrous decisions and a failure of leadership at many levels contributed to the disaster. Not only was the Piper Alpha disaster entirely avoidable, it had been predicted, by onshore and offshore personnel.

- Dick:** You heard about him though?
- Bob:** During the inquiry I got to know the story.
- Dick:** He was a rigger. On Piper. 7th September '87. He was attaching heavy lifting gear to some overhead beams and he fell to the deck. They medevac'd him out, but he died of his injuries.
- Bob:** That's what I heard.
- Dick:** But he wasn't meant to be doing that! His Permit To Work said he was meant to 'check and repair the thrust bearing'. But he was replacing the bearing which he should not have been doing.
- Bob:** We've already established that the Permits To Work were useless.
- Dick:** But Occidental had an opportunity here! They could have improved matters! They could have said, 'look a man has died on one of our platforms and he died because we're not doing things right – we're not making sure that we are putting men to work safely'. But they didn't. In fact they tried to hide it.
- Bob:** How so?