SAFE WORKING ESSENTIALS
GUIDANCE DOCUMENT

Working together
to continuously improve our safety performance
Preface

Approximately 5.3 million man-hours can be released over one year by simply saving an offshore worker 1 hour in their working day. This can be achieved in part by simplifying safety observation systems, dynamic risk assessments and standardizing toolbox talks.

Safe Working Essentials is a suite of tools covering these three elements which are fundamental to reducing the likelihood of accidents at work.

The Safe Working Essentials has been prepared for the benefit of the entire UK Oil and Gas Industry, as part of the Simplification work stream. It consists of three tools; the Toolbox Talk, the Dynamic Risk Assessment and the Observation Card. These tools were designed in accordance with the best practices identified in an assessment and gap analysis of all the tools used by industry operators and contractors. The tools are provided in a pocket-book format to make them easy to use at the point of work and come with a short guide to their use and this Guidance document, which provides the background and details of the various tools.

Safe Working Essentials clarifies the Role and Responsibilities of the Organisation, Teams, Supervisors and Individuals to use the tools to best effect and discusses the importance of After Action Reviews to capture and disseminate lessons learned in order to improve safety at the worksite and within and across organisations involved in the industry. The Observation Card system and how to collect, categorize and provide feedback on safe/unsafe acts and conditions is also discussed.

This guidance expands upon the objectives of toolbox talks, dynamic risk assessments and observation cards and can be used to support the use of the Safe Working Essentials card by illustrating the background to development of the tools and outlining expectations of industry uptake.

Safe Working Essentials process

- Complete Readiness Review
  Request a readiness review from Step Change in Safety. This is the first step to take to self- assess how ready you are at a company, site and individual level to standardize existing systems and convert to SWE. Once completed, you should discuss your results with a member of the Simplification team.

- Request a folder
  This folder contains all the material you need to make this work at site. All material is intended to go to the worksite – there is a USB stick within the pack containing electronic copies of everything. You can request a folder by emailing Simplification@StepChangeinSafety.net

- Request boxes
  Step Change members are entitled to receive 3 boxes free of charge. Each box contains 100 booklets. Email Simplification@stepchangeinsafety.net to get these sent to you.

- Attend a Community of Practice meeting
  These meetings are held every 2 weeks to share experiences and learn from other sites. This is a great opportunity to identify any problems which may occur and ways in which other companies dealt with them.
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Background

All work tasks must be evaluated in order to identify the hazards and associated risks, identify the appropriate control measures, recognize and understand the barriers and precautions required and to demonstrate that the risks have been reduced to As Low as Reasonably Practicable (ALARP).

The Management of Health and Safety at Work Regulations give details under the Health and Safety at Work Act which relate to the controls of work activity and risk assessment. These regulations apply to all work places in the UK, including offshore installations.

Industry Need

In 2006, Step Change in Safety launched a campaign called ‘Boots on for Safety’, which involved industry leaders visiting platforms and rigs in the Oil and Gas industry to listen to workforce views and ideas about safety. A number of issues were identified as improvement opportunities, namely the need for a common approach to intervention systems, too much paperwork for people to get through before starting a job and that STOP cards are being used as a numbers game. These issues were still significant in 2016. There was therefore a need to have one system in place to share information from Step Change member organisations, the workforce and other sectors such as fire, military and police. By pulling together all the knowledge and experience accrued over the decades, the industry could achieve the best possible systems and processes to improve safety and efficiency.

As a result of the workforce feedback, Step Change in Safety created a new work stream called ‘Simplification’ to progress these issues. Simplification is directly linked to deliverables from the Scottish Government and Energy Jobs Task Force, and is supported by Oil and Gas UK. The aim is to streamline work processes to make them simpler, more engaging and sustainable for all.
As part of the Simplification work stream, the intention is for Safe Working Essentials to be adopted throughout the whole UK Oil and Gas Industry.

Step Change in Safety led the introduction of MIST training through the OPITO standard in 2009 and the program is already central to Simplification, but its value can be further maximized through Safe Working Essentials.

Standardizing and simplifying common elements such as toolbox talks, dynamic risk assessments and safety observation cards will allow a rapid development and deployment of a standardized approach. Industry buy-in is critical.

The development team analyzed the processes used across the entire UK oil and gas industry and found remarkable similarity from one process to the next. Even though an individual process may be good, the benefit to the entire industry to make the process simpler and more consistent will have a positive impact on safety as the large number of workers who travel from one facility to the next only need to learn a single process. This will give them the opportunity to improve on the process thus saving on wasted training time, effort and money and, through reduced complexity and variety, improve understanding and therefore safety performance.

**Simplify**

Simplification is a major step towards cost efficiency and collaboration. The objective is to standardize where possible throughout the oil and gas sector. This will eradicate the confusion and complexity surrounding safety initiatives. It will also eliminate repetition, reduce costs, be more sustainable and, ultimately, help keep the workforce safe.

**Engage**

A key aspect of Simplification is to allow the workforce to get on with their work more efficiently and in a safer manner. Simplification is a compelling argument for cost efficiency and collaboration but difficulties may arise between operators and contractors in choosing one system to use; all members have already invested time and money in their own systems. A gap analysis was therefore conducted to review all oil and gas operator and contractor in-house documents and identify any overlaps, identify key themes and highlight best practice. This document outlines the best practices that were consistently used by the industry.

**Sustain**

To sustain safe working essentials there will be a requirement for both operators and contractors to adopt the tools within their local control of work processes and share the lessons generated in an industry wide continual improvement network.
The Organisation, the Team, the Supervisor and the Individual each have important roles and responsibilities to fulfil in using Safe Working Essentials. These are outlined below.

The organisation should ensure that the Safe Working Essentials tool is supported and endorsed by the leadership team. There is a requirement to make the tool available to all assets, sites and also within the supply chain.

The team is responsible for using the tool to collaborate, communicate and support their day to day operations. The supervisor is the leader of the team and plays a critical role in conveying information about the task, its location, hazards and risks, the location of emergency equipment and other key information. The supervisor and the rest of the team have a responsibility to encourage all members to contribute and participate effectively to achieve best use of the tool.

When using the tool individuals should maintain a questioning attitude and call upon their situational awareness when performing tasks. The tool is designed to deliver feedback where required and the individual should seek this throughout the process.
**Process Flow**

**Notes**
- Permit to Work
- Task Risk Assessment
- Task Instruction
- Dynamic Risk Assessment at the worksite
- Previous Learnings

- Where
- Why
- What
- How
- Who

**CONTINUOUSLY ASSESS THE SITUATION FOR CHANGES**

**STOP THINK ACT REVIEW**

**Complete the task**

**After action review**

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*Figure 1*
Description

There are a number of steps to the completion of any task. For the effective delivery of a TBT and completion of the task the following steps are key:

**TBT Prepared** – review the organisation’s control of work paperwork relevant for the task (permit to work, task risk assessment, job step plan) and identify those items required to be communicated via the TBT (Why, What, Who, Where, How, When). To aid the TBT leader in this task a TBT form has been developed allowing a structured approach to the preparation. An example of this can be found in the appendices.

**TBT Delivered** – the delivery of the TBT should be completed in a manner that generates the following actions; engagement, listening, questioning, confirmation and ensures that the team contribute with; energy, concentration, commitment and understanding of the task. Key to the TBT is confirmation of understanding by all team members in their role and the requirement to stop the job if the situation changes at any time. The TBT is completed by the work-party just before the start of a job.

**Commence Work** – the team should commence work in line with the plan and ensure that the control measures outlined in the TBT are followed.

**Recognition of Change** – at all times throughout the task the team should be monitoring closely for any situation changes that may require the team to stop the task and review the impact of the change. A change could come in a variety of forms such as; weather, equipment not working as planned, fatigue of the team, or by a new member joining the team. An example of how to deal with change can be found in the appendices.

**Stop, Think, Act, Review (STAR)** – Once it is recognized that a change has occurred, the team should stop the activity and think through the implications of the change in the task. The best way to do this is to assess the risks via a Dynamic Risk Assessment (DRA). Once the risks have been assessed it may be that the task requires further control measures. These should be communicated to the team prior to the task re-commencing.

**Note:** there may be occasions when the change is such that the task requires to be stopped and the task risk assessment amended to reflect the change. If the control measure is such that this does not require to be documented on the TRA then it is recommended that an Observation card is completed to allow for the learnings to be communicated.

**Complete the Task** – once the task has been completed then the worksite should be left in accordance with the organisation’s procedures. The team should also be made aware that an After Action Review will be undertaken.

**After Action Review** – the AAR allows the team the opportunity to review the task recently completed to identify any good practices and learnings that the team would recommend to the organisation. The AAR learnings should be communicated by using the Observation card to allow for the correct action.

**The Permit**

According to the Health and Safety Executive, a permit-to-work does not just give permission to carry out a dangerous job and should not be regarded as an easy way to eliminate hazards or reduce risks. It determines how that job can be carried out safely, and helps communicate this to those doing the job. **A permit, in itself, does not make a job safe.** Safe execution of the job is achieved by proper preparation, proper supervision and by the people carrying it out. The permit-to-work system should ensure that authorized and competent people have thought about relevant hazards and foreseeable risks and that such risks are avoided by using suitable precautions, e.g. electrical isolations or barriers to access. Those carrying out the job should think about and understand how they are going to carry out their work safely, and take the necessary precautions for which they have been trained and made responsible.
Hierarchy of Control

Throughout the process those preparing and executing the task should ensure that they minimize the risk to the workforce by applying the Hierarchy of Control. When reviewing the documentation to prepare for the TBT the control measures should be clearly reviewed to ensure that the team understands them and do not deviate from the stated mitigations.

Figure 2
Toolbox Talks

Introduction

There are many TBTs held every day and some are better than others. There are numerous different TBT formats with different processes and different terminology. The differences are generally minor in nature as the TBT process is essentially similar.

There is no defined timeframe for how often a TBT should be undertaken. It is clear that it should be completed at the start of a task and it is helpful to re-visit the TBT when new members come onto the task. If the task spans shifts or days then the TBT should still be conducted by each work party to ensure that they are all still aware of the requirements of the task and where they can find emergency equipment (MAC point, telephone, eye wash, etc.) A TBT should always be done when someone new joins the team performing the work, irrespective of when the last TBT was done. In relation to how long a TBT should last, the answer is that the duration should be long enough to ensure that everyone involved with the task fully understands their role and the actions to take in the event that something unexpected happens, including where to find emergency equipment.

Step Change in Safety reviewed what was available across industry and have developed this guide based on best practice. A common TBT process will help achieve the Step Change in Safety goal of standardization and simplification across the UK oil and gas industry, which is considered essential to further improving safety performance and driving efficiency.

This guide is intended to help you, and everyone else across the industry, to deliver better Tool Box Talks.

Responsibilities

The Duty Holder has overall accountability for safety at your facility and as such, is responsible for organizing Task Risk Assessments (TRA) and Permits To Work (PTW) in accordance with the established company processes. You may have been involved in planning and preparing for the work and this is always good practice. Once assigned to perform the work your first duty is to prepare for the TBT.

The TBT Guide included in the Safe Working Essentials tool kit is designed to ensure that you do not overlook any aspect of preparing and delivering the TBT.

Use the form to make notes to help you deliver a better TBT to your team.

Non-Permitted and Lone Work

Non-permitted worked, often referred to as routine or low risk tasks, and the rules and processes used to manage this are detailed in each duty holder’s control of work system. There are many ways to manage this work so these Safe Working Essentials do not try to describe how the tool box talk process specifically fits with any of these processes other than a tool box talk should be performed.

Many low risk tasks are performed by lone workers and clearly, it isn’t possible to actually present a tool box talk and engage others if you are the only person there. None-the-less, the principles of the tool box talk process can be used and the simple act of using the Safe Working Essentials TBT guide as an aide memoire before the work starts will help assure the work is performed safely. Equally the Dynamic Risk Assessment and Observation Card processes can be followed when working alone.
Prompts

The Safe Working Essentials and the TBT form have prompts to help you remember everything you need to know to deliver the process effectively. The more you refer to these the sooner you will find the process becomes second nature. Even when you know this process well it is still useful to refer to the prompts to allow your mind to focus on the task, the associated hazards and the controls required to ensure the task continues safely.

Communication

The TBT is always delivered before the task begins though may be repeated in all or in part when a new person joins the team and also at the start of each shift to refresh understanding and talk through the next steps of the task.

It seems obvious but a TBT is primarily about communication. A good TBT involves a lot more than just talking. Details of how to communicate well delivering a TBT are provided below in ‘How to deliver your TBT’.

Video

There is a Step Change in Safety Tool Box Talk video available which shows good delivery practice in support of this guide.
Toolbox Talks

PREPARATION

Review the necessary documentation

The first step is to review all of the documentation that will support and control the work. This could include:

- Risk assessments
- Permit and certificates
- Work order
- Drawings and technical instructions

Understand the task

All tasks are easiest to understand when broken down into steps. It is useful to identify when the task should be paused to update the team on the next steps and confirm responsibilities. This is especially important when approaching potentially higher risk aspects of the task. Key pauses between steps are often called ‘hold points’. These are also excellent opportunities to do DRAs.

A comprehensive understanding of the task is essential before moving on to the next step, as well as being aware of any previous lessons learned from observation cards fed into the task risk assessment.

Be able to explain the task to your team

You need to be able to explain what is involved in the task, where it will be performed, when the hold points are, and who has the key responsibilities for which parts of the task.

Decide where to deliver the TBT

The best place to deliver the TBT is the work place though only if conditions are suitable. Where the work place has high noise, poor lighting, or is likely to be affected by poor weather conditions then a more suitable location for the TBT needs to be found.

This needs to be communicated to your work team in plenty of time as they too may need to prepare for the TBT.

What to include in your TBT

You can use the TBT form to make notes so you make sure you don’t overlook any aspect during your delivery. You have enough to remember without trying to memorize every step in this process and your team may well have questions and the form will help keep you focused.

Visit the workplace

The next step is very important and the most often missed out; going to see where the task will be done.

Physically going to the workplace allows you to see how the TRA and PTW controls will be used in the environment where the task will be done. There may be other tasks being performed nearby, above or below, and weather could be an issue. This is also your first opportunity to do a DRA to support the task preparation work already completed.
At the top of the front page of the form there are boxes for reference purposes:

- Installation / Location
- Work Order / Permit Number
- Date

### Preparation List

- Necessary documentation ready
- TBT location selected
- Key TBT steps prepared
- Worksite visited

This information supports the flow of the TBT guide in the tool.

The next 6 sections structure the TBT around the following areas:

- **WHY** Reasons for the task, any previous lessons learned?
- **WHAT** Overview of the task and hazards
- **WHO** Who else is supporting the activity? Any resource requirements?
- **WHERE** Worksite overview, including simultaneous operations (SIMOPS) and weather
- **HOW** Break into steps, agree hold points, who is responsible for what?
- **WHEN** Time of job, stop job triggers

On the back of the page there are also hazard prompts to aid identification of hazards and energy sources which could impact the job. These are explained further in the next section.

The last section gives room for the TBT Leader/Supervisor and the work-party to add their names to confirm attendance, and requires completion by those present.

An example of a completed Toolbox Talk form can be found in the appendices.
Hazard Identification

Hazard identification prompts and Energy Sources are included on the toolbox Talk form. This is to aid delivery of the toolbox talk and generate conversation around acts and behaviour, and conditions and consequences.

These icons are shown by red circles and triangles to align with the HSE 164 Safety Signs and Signals Regulations 1996 and the Highway Code. Circles represent mandatory rules and triangles represent warnings.

### Hazard Identification

#### ACT/BEHAVIOUR

- Obtain authorisation before entering a confined space
- Protect yourself against a fall when working at height
- Follow the lift plan and do not walk under a suspended load
- Operate vehicles safely (don’t use mobile, wear seat belt, follow journey management plan)
- Work with a valid Work Permit when required
- Verify isolation before work begins and use the specified life protecting equipment
- Prevent dropped objects
- Position yourself out of line of fire in relation to moving and energised equipment
- Obtain authorisation before starting excavation activities
- Obtain authorisation before overriding or disabling safety critical equipment

#### CONDITION/CONSEQUENCE

- Gravity
- Temperature
- Motion
- Sound
- Mechanical
- Chemical
- Electrical
- Radiation
- Pressure
- Biological

### Act/Behaviour

In this context, an act or behaviour is carried out by a person and should be observed by all people whilst undertaking the task. It is a physical activity which can be witnessed to be undertaken in either a safe or unsafe manner. These circle icons are mandatory considerations.

These icons have been developed by analysing what organisations already had in place and are aligned with industry standard IOGP Life Saving Rules. Some of the OGP life saving rules icons have been combined into one – such as ‘Follow the lift plan and do not walk under a suspended load’ and ‘Operate Vehicles Safely’, to simplify the process. Some icons – such as alcohol/drug awareness and smoking procedures - have deliberately been left out as they are better suited to on site house rules.

### Condition/Consequence

A condition or consequence are aspects of the task which could go wrong if not considered properly. It can be safe or unsafe and in relation to a physical condition that has been witnessed. The triangles indicate a hazard and have been developed as energy sources which are recognised throughout industry.

These icons have been designed to generate conversation. Rather than a traditional route of ‘trapped hand’ this would be identified via a conversation around ‘motion’, for example.

The human element should be considered in all aspects of hazard identification. This has been indicated by the DRA logo on the toolbox talk form.
How to deliver your TBT

✅ ENGAGE

Anyone can stand and talk, and some people are more comfortable than others talking to groups of people. To effectively deliver a TBT you have to engage the others in your team. To do this you need to communicate well with each one of them and this requires eye contact. If you don’t look at each person and make frequent eye contact you aren’t communicating as well as you could be. This is a skill and so the more you practice this the better you will become at it.

Good communication also requires energy from you and from the people in your team. Be positive, you already fully understand the task, you have visited the work place, and you are both confident and comfortable explaining the task to those present at your TBT. If you keep your energy levels up this will be evident to your team and they will be inclined to respond positively to this and add their energy.

✅ LISTEN

Everyone present must listen to what is being said. Listening isn’t just hearing, it’s being able to explain back what has been heard and demonstrate understanding of the message, not just the words. Listening requires concentration so avoid distractions and control interruptions.

✅ QUESTION

You need to ask people questions to give them the opportunity to demonstrate their understanding. A good TBT ensures everyone present talks at some point. Questions ensure that those amongst us that are perhaps more reserved or quiet by nature also have the opportunity to speak and to demonstrate understanding. Just because someone is naturally quiet shouldn’t mean they do not get their turn to speak.

When someone asks a valid question this demonstrates their commitment to wanting to fully understand their elements of the task. Every good question should be acknowledged as such and people do appreciate being thanked for asking good questions.

✅ CONFIRM

If your TBT has gone well you will have ensured good communication, have checked for active listening and had many questions that demonstrate that your team understand the task and all it involves. The last step in the TBT is to confirm with everyone present that they understand the task and to ask if they are comfortable to proceed.

Once this is confirmed you can sign the TBT form and ask everyone else present to sign the form.

You are now ready to start the task.

The TBT should be reviewed and an update provided to the team after each break in the work and at the start of each new shift. These are also excellent opportunities for Dynamic Risk Assessments.
Dynamic Risk Assessment refers to the continuous assessment of risks arising from potential hazards, in the ongoing and changing circumstances of work activities. For example, changes in weather conditions or realizing that a critical piece of equipment is missing. This ongoing assessment is a necessary part of safe working in order to identify any changes in the working environment, work task or personnel so that appropriate control measures can be implemented, thus reducing risks to As Low as Reasonably Practicable (ALARP).

The benefits of proceeding with a task must be weighed against the risks. This means ongoing assessment of what may have changed in the situation and stopping to think before taking action. This can be summarized by Stop, Think, Act, Review (see below).

In order to do this, it is necessary to maintain situational awareness. This involves using all Senses (sight, hearing, smell) (or Observe), to receive information from the environment around you. The next stage is to Orient by considering prior experiences or other people's experiences and the impact these could have on you and/or others. The next stage is deciding on the course of action to take based on the best possible outcome of the action. The final stage is to take action to improve the situation, thus keeping risks ALARP.
The diagram below recommends that situational awareness can be maintained by conducting a 360 degree appraisal in the area up to 5 meters away from you but remember to use ALL your senses as the threat or hazard may come from further away, e.g. a crew preparing for lifting operations in the near vicinity.

Figure 3 – 360 degree appraisal

A number of additional factors might contribute to the current course of action being too risky, so it is important to recognize any changes to the situation. For example, new hazards and their risks might arise or existing hazards may present different risks. Operational activities might change requiring reactive rather than proactive decision making and signs of fatigue in personnel should be monitored and addressed.

It is important to never be complacent about risks, as they will always exist and sometimes show up in unanticipated ways. Taking risks does not always end up in gaining benefits. If the unanticipated does happen, then gather information for an After Action Review and debrief. The Observation card should be used for this. Recording instances of unsafe acts and unsafe conditions is important for learning lessons that can be shared with the wider industry.
Observation Card

Introduction

The observation card (OBS) has a logical place in the suite of work site tools, fully complementing TBT and DRA. As part of the Simplification process, the OBS card has been produced from the good practice found in many of the industry observation systems. The OBS card links all the elements of the tool suite together and can be used to record any change resulting from a DRA, AAR or any other observed unsafe act or condition, e.g. a cable lying across a walkway.

The most important aspect of any observation system is to identify and deal with any issue and then record it for further analysis in order to learn lessons. The most common complaint with observations systems is that the contributor does not receive feedback. The Safe Working Essentials OBS card closes the loop and requires that feedback be given. This enables recognition of both positive and negative observations and ensures that the learning process is sustained throughout the industry.

Responsibilities

**Organisation:** The organisation should ensure that the OBS cards are available to everyone and are used by all companies (duty holder, contractors, supply chain) on an offshore installation or onshore location. It should provide a system to collect the cards and ensure that the cards are reviewed and appropriate feedback given.

**Team:** The team should encourage colleagues to use the OBS cards and review any cards submitted at the AAR stage, to identify any lessons learned that could improve how tasks are conducted in the future.

**Individual:** The individual is responsible for recording observations, any changes and actions arising, to submit to the organisation’s system in a timely manner. The individual must ensure that the OBS card is given to their supervisor.

Preparation/Use

**Front Page:** The front page of the OBS card asks for details such as name (required for individual feedback), location, date/time and what category of event has been observed and is being recorded, i.e. safe/unsafe act or safe/unsafe condition.

**A conversation** relates to the actually physical activity of holding a conversation between an individual or group. The holding of a conversation is normally proactive and used to identify potential risks and hazards before they occur. An example of this could be when a supervisor visits the worksite to discuss with the team the activity they are about to undertake, although conversations are not just limited to supervision. In a reactive manner we can use conversations to intervene when we see and unsafe act or condition therefore preventing injury. Conversations should be held in a manner that is not threatening and one that creates trust and respect between those involved. An equally aspect of the conversation is to ensure that those people involved are actively listening to the words that are communicated and the conversation is kept focussed on ensuring the highest levels of performance.

**An observation** is more reactive in its approach in that it is normally in response to physically witnessing an unsafe act or condition. There may be occasion when an unsafe condition is witnessed that requires to be reported so that learnings can be communicated, an example of this could be noticing that barriers have moved due to not been secured, after securing the barriers to prevent access you would generate an observation card based upon what was seen and the action taken.
An act is a physical activity that is witnessed to be undertaken in either a safe or unsafe manner. An example may be the correct use of a tool (safe act) or working at height without a fall restraint (unsafe act).

A condition again can be safe or unsafe and in relation to a physical condition that has been witnessed. An example could be the correct use of barriers to control access (safe condition) or a pool of oil on a solid deck, which has not been cleared up (unsafe condition).

When observing an unsafe act or condition remember we are all responsible to intervene and make the condition safe to prevent an occupational safety, process safety or environmental event.

The next section asks what the individual has observed (i.e. the event or situation) or what change has been recognized. The following section asks what the individual has done about it – how was the situation or event dealt with and who was told about it? The final section asks what the team should do about it. There is an opportunity here for the team to record what could be done to prevent this event/situation happening again, for example by changing how the task is planned and executed.

Back Page: the back page is where feedback is given. For the individual, this could range from verbal thanks and acknowledgement of the OBS card, or further discussion to explore the observation as part of the After Action Review. For the team, this is the opportunity to give feedback on any observations or change management. Finally, for the organisation, the feedback is at a high level and related to any alerts or changes to procedures.

Check boxes for Feedback are given along with a space to include a relevant reference number, so that changes can be tracked within an installation, site or organisation’s system, or link to the permit. There is also the ability to mark with an X any hazards which have been identified in the process.

Feedback Loop

Feedback is an important part of the observation process and it should be delivered at the individual, team and organisational level. Depending on who processes the observation cards, the supervisor or perhaps the HSE advisor/coordinator is responsible for feedback at the individual and team level. At this level, the lessons learned can be shared with individuals and teams engaged in the same task in the future.

Each organisation will have its own system for categorizing observations raised and for trending the data. The supervisor or HSE advisor/coordinator will be responsible for feeding OBS cards into the system where they can sort into the appropriate category by the corporate HSE team. The reference number can be used in a number of ways relevant to the task. This could be the permit number, the work reference, a person’s name, etc.

An example of a completed observation card can be found in the appendices. The example shows how to record change.
After Action Review

Introduction

An After Action Review (AAR) is a structured method of reviewing how a task has been planned and executed. It focuses on the same headings mentioned in the tool box talk (Why, What, Who, Where, How & When) to review from the task participant’s perspective what went well or could have been planned or executed better. The application of an AAR allows for learnings to be identified and shared across an organisation to improve both safety and performance.

The AAR focus on the intended results versus the actual results achieved allowing individual input from experience during the task.

Responsibilities

The responsibilities for an After Action Review vary dependent on the type of AAR (formal or informal). A formal AAR is designed to be held at an organisational level and tends to focus more on major projects or activities in relation to gathering learnings for knowledge sharing across future activities. An informal AAR is more appropriate at a team level and is a less time consuming approach while still ensuring that learnings are captured.

Organisation – the organisation is responsible for providing a mechanism for any lessons learned to be shared in a manner that is sustainable. The organisation should support the AAR process and empower team leaders to feedback results at the end of relevant tasks by ensuring that time is allocated in the planning process.

Team – the team are responsible for ensuring that they complete an AAR and feedback any lesson learned by the use of the observation card. The team leader in particular has a pivotal role in ensuring that all members of the team are engaged in the process and the necessary feedback is given prior to moving onto the next task.

Individual – it is the responsibility of each individual to ensure that they engage in the AAR process to identify lessons learned from the task that has been undertaken. These lessons, if dealt with appropriately, can give future improvements in safety and performance for other similar tasks.

Preparation

The AAR should be prepared for by ensuring a suitable place to review the task that has been undertaken. A good starting point would be to review the Tool Box Talk that was completed at the start of the task and follow this through ensuring that each of the team contributes as required using the questions outlined below.

Communication

As part of the AAR the communication should be; engaging, energetic, reflective of the task undertaken and allow others involved with the task to ask questions. Some of the steps/questions you may wish to consider are:

- What was supposed to happen?
- What did happen?
- What are the improvements?
- What are the good practices?

Summary of the AAR

Once the AAR is complete then any observations should be entered onto the Observation Card to ensure that learnings are passed to the organisation. There is a useful After Action Review leaflet in the Starter folder which was created by a site piloting the toolkit which provides further information on how to conduct an AAR.
Appendices

Appendix 1; Acronyms & Definitions

AAR  After Action Review
ALARP  As Low As Reasonably Practicable
DRA  Dynamic Risk Assessment
MIST  Minimum Industry Safety Training
OBS  Observation
OPITO  Offshore Petroleum Industry Training Organisation
PTW  Permit to Work
SIMOPS  Simultaneous Operations
SWE  Safe Working Essentials
TBT  Toolbox Talk
TRA  Task Risk Assessment

Appendix 2;

Observation Card

**OBSERVATION CARD**

Name: ____________________________
Location: ____________________________
Date/Time: _______________________
Company: ____________________________

Type of observation (please tick)

- [ ] Conversation  [ ] Safe  [ ] Act/Behaviour
- [ ] Observation  [ ] Unsafe  [ ] Condition/Consequence

What did you observe or what changed?

What did you do about it?

Did you stop the job?  [ ] Yes  [ ] No

<table>
<thead>
<tr>
<th>What could we do about it?</th>
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Individual/Team/Organisation Feedback

Hazard(s) Identified (mark with X as identified)

Not Listed: ____________________________

Feedback given?  [ ] Yes  [ ] No

Reference: ____________________________
HOW TO USE THE OBSERVATION CARD

Location
This is your workplace – eg Beatrice Platform

Date/Time
This is the date the observation occurred and approximate time – not the time the card is completed

Company
This is your employing company

Type of observation
Conversation; This is when you speak to a person
Observation; This is when you see something worth reporting
Safe; when something is seen to be done safely and correctly
Unsafe; when something is seen to be not correct and unsafe
Act/Behaviour; a physical action witnessed to be undertaken
Condition/Consequence; a physical condition of something

What did you observe or what changed?
This is where you state, in your own words, what has been observed or what change has been recognized

What did you do about it?
This is where you record how the situation was dealt with and who was told about it. This is where you indicate whether you stopped the job.

What could we do about it?
This is an opportunity for the team to record what could be done to prevent this happening again, for example how to improve the task for next time.

Individual/Team/Organisation Feedback
For the individual, this feedback could be verbal thanks or acknowledgement, or further discussion as part of the Action Plan Review. For the team, this is the opportunity to review any feedback or change management considerations. The organisation feedback is at a high level and related to any shared alerts.

Hazard Identified
These Hazards share principles with the Highway Code – a circle is a rule and a triangle is a warning. These are explained further on the toolbox talk form. Mark with a X which hazard has been identified.

Not Listed
This is to be completed when the hazard you have identified is not listed.

Feedback given?
Each organisation will have its own system for categorising observations raised and for trend the data if required. This feedback loop can be to the team or individual, as you choose to do it.

Reference
This can be used in a number of ways relevant to the task – such as permit number, work reference, etc.

Simplification
Working together to continuously improve our safety performance
Appendix 4; Toolbox Talk and Dynamic Risk Assessment

**KEY STEPS; TBT, DRA & OBS**
- TBT prepared
- TBT delivered
- Commence work
- Complete the task
- After action review

**TOOL BOX TALK GUIDE**

**PREPARE:**
- Visit workplace
- Understand the task
- Be able to explain the job to your team

**DELIVER TALK:**

**WHY**
- Reasons for task
- Any previous lessons learned?

**WHAT**
- Explain the task, hazards and review controls

**WHO**
- Who else is giving support to the activity? Any resource requirements?

**WHERE**
- Worksite overview, including SIMOPs and weather

**HOW**
- Break into steps
- Who is responsible for what?
- What to do in an emergency

**WHEN**
- Time of job, stop job triggers

**CHECK UNDERSTANDING:**
- Ask questions
- Is everyone comfortable to proceed?

**DYNAMIC RISK ASSESSMENT**

**USE ALL YOUR SENSES TO CONTINUOUSLY IDENTIFY HAZARDS THROUGHOUT THE TASK**
- Use your experience to evaluate the situation
- Could you or your colleagues get hurt?
- What can you do about it?
- Evaluate options based upon reducing risk
- Add additional control measures
- Recommence the activity
- Generate Observation Card for sharing of learnings
- Complete task after action review
- Reassess systems of work

**SAFE WORKING ESSENTIALS**

**TBT**
- Tool Box Talk
- An effective TOOL BOX TALK will include these elements:
  - ENGAGE
  - ENERGY
  - LISTEN
  - CONCENTRATION
  - CONFIRM
  - UNDERSTANDING

**DRA**
- Dynamic Risk Assessment
- Use ALL YOUR SENSES TO CONTINUOUSLY IDENTIFY HAZARDS THROUGHOUT THE TASK

**OBS**
- Observation Card
- Observation Card
- Observation Card

**STEP CHANGE IN SAFETY**

**SAFE WORKING ESSENTIALS**

**TBT**
- Tool Box Talk
- Revision 2
Issued January 2017

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## Toolbox Talk Form

### Installation / Location:

### Work Order / Permit Number:

### Date:

### WHY

- Reasons for task, any previous lessons learned?

### WHAT

- Explain the task, hazards and review controls

### WHO

- Who else is giving support to the activity? Any resource requirements?

### WHERE

- Worksite overview, including SIMOPs and weather

### HOW

- Break into steps, who is responsible for what? What to do in an emergency

### WHEN

- Time of job, stop job triggers

### PREPARATION LIST

- Necessary documentation ready
- TBT location selected
- Key TBT steps prepared
- Worksite visited
PREPARATION TIPS:
Review the necessary documentation (permit, risk assessment, task instruction)
Select somewhere to deliver the TBT that assists with listening and understanding
Our brains typically remember a few things best so consider ‘chunking’ the job

DEVELOPMENT OF TALK TIPS:
Be confident in your delivery
Keep it interactive and ensure you engage with the team – look them in the eye
Keep it relevant to the task and do not get distracted
Identify & clarify responsibilities
Use clear & concise language – avoid acronyms and technical language

HAZARD IDENTIFICATION

ACT/BEHAVIOUR
- Obtain authorisation before entering a confined space
- Protect yourself against a fall when working at height
- Follow the lift plan and do not walk under a suspended load
- Operate vehicles safely (don’t use mobile, wear seat belt, follow journey management plan)
- Work with a valid Permit when required

CONDITION/CONSEQUENCE
- Gravity
- Temperature
- Motion
- Sound
- Mechanical
- Chemical
- Electrical
- Radiation
- Pressure
- Biological

CHECK UNDERSTANDING
Opportunity given to ask questions
Everyone is comfortable to proceed

TIPS:
Ask relevant and open questions to confirm understanding with team. Is there anything you do not understand.

TOOL BOX TALK ATTENDEES

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<tr>
<th>Name</th>
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<tr>
<td>TBT Lead</td>
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Flange found to be leaking due to cracking of the epoxy resin and requires to be replaced. Although we have completed a few similar spool change outs we should not be complacent and ensure that we are diligent - yesterday there was a near miss on another job that involved poor barrier control. Make sure ours are all in order.

Hazards; trapped pressure [isolations in place], use of tools (air pressure, cuts) [competent people & pre-use checks], poor communication [TBT & DRA (stop the job authority)], occupational injury (fingers/ hands) [keep out of the line of fire, manual handling (posture & equipment) [techniques & competency], liquids in the pipework [spill kits], dropped objects [individual, housekeeping], occupational hygiene - COSHH, task- removing spool

Operations have completed the isolations, the deck crew will bring the spool arrangement to the work site, the team involved with the removal/ fitting of the spool are the engineering & construction team, fabric maintenance will complete the painting and operations will complete the commissioning/ testing.

This will be completed in area XX on module A working on the firewater system. There are a number of other workscopes being undertaken in our direct area, none of these are hot work although we should ensure we continuously assess those in our vicinity. The weather is

The total time to do this task is 26 hours so today we will focus on the first 7 hours which will cover the removal of the spool. (the next shift will fit the spool). The steps are:

1. Identify the existing spool - Team leader will identify the spool and it will be verified by the operations supervisor
2. Undertake the rigging and lifting as per the lift plan to give temporary support - the team will do this step with support from the asset lifting focal point (note prior to lifting there will be a hold point to check we are safe to continue)
3. Break the flanges - the team will complete this using air equipment and manual tools
4. Remove the spool using the lifting arrangement - team to complete with assistance from lifting focal point

Time of job, stop job triggers
Observation Card – how to record change

**OBSERVATION CARD**

Name: Bill Smith
Location: UKCS-A
Date/Time: 24/6/16 1545
Company: Oil Gas Ltd

**Type of observation** (please tick)
- [ ] Conversation
- [ ] Safe
- [ ] Act/Behaviour
- [x] Observation
- [x] Unsafe
- [x] Condition/Consequence

**What did you observe or what changed?**

Line B was meant to be isolated but felt it was vibrating when made contact with hand as if there was a flow through it.

**What did you do about it?**

Did you stop the job? [x] Yes  No

Stopped Work and communicated to team and supervisor. Advised team to stand down.

**What could we do about it?**

Liaise with ops and verify isolations.

**Individual/Team/Organisation Feedback**

Checked and verified - the line had been isolated but vibration was being transferred from work nearby on platform. Good to stop the job and check.

**Hazard(s) Identified** (mark with X as identified)

Not Listed: 

Feedback given? [x] Yes  No

Reference: 24616 - 1545BS