



# Moving from Telling to Action

Matthew Ames, Group Manager HSSE,  
Origin

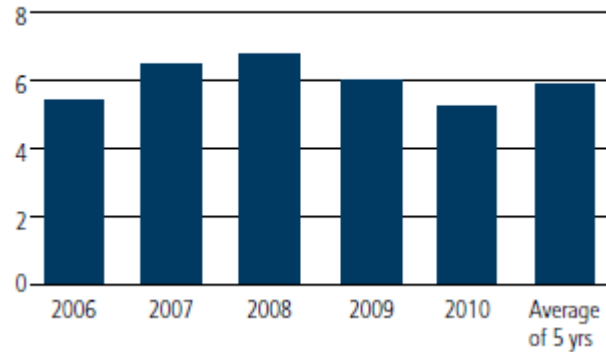
DrillSafe Forum | 7 June 2012

# Despite much talk there is generally a plateau of performance

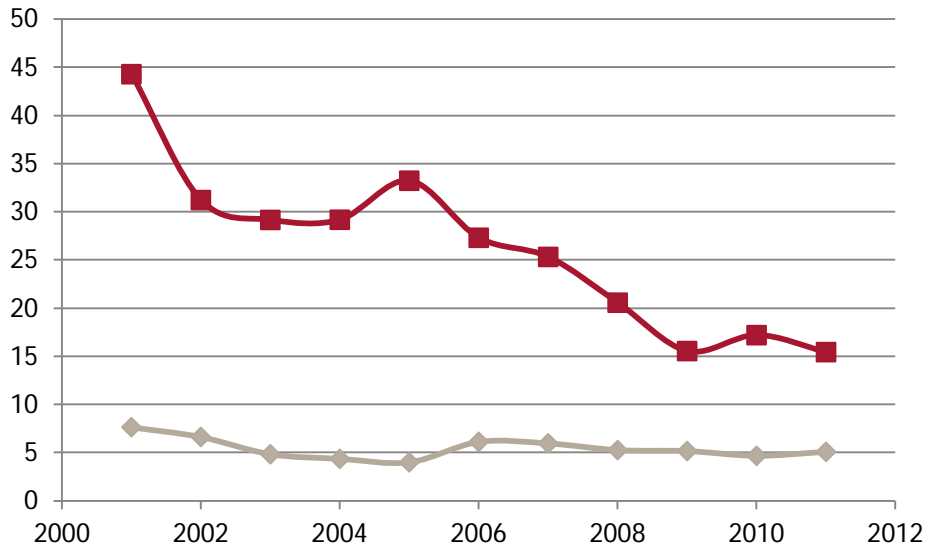


## APPEA

Total recordable injuries per million hours worked among APPEA members



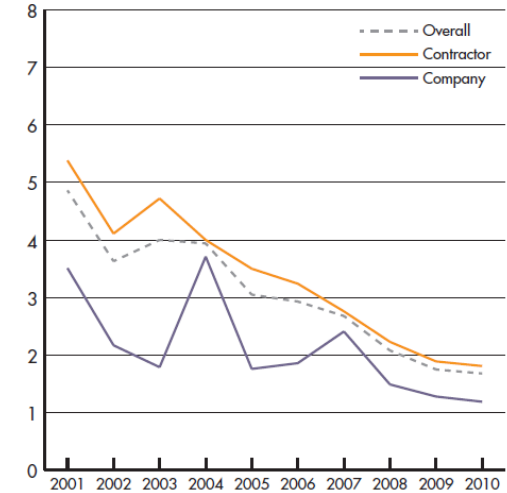
## IADC



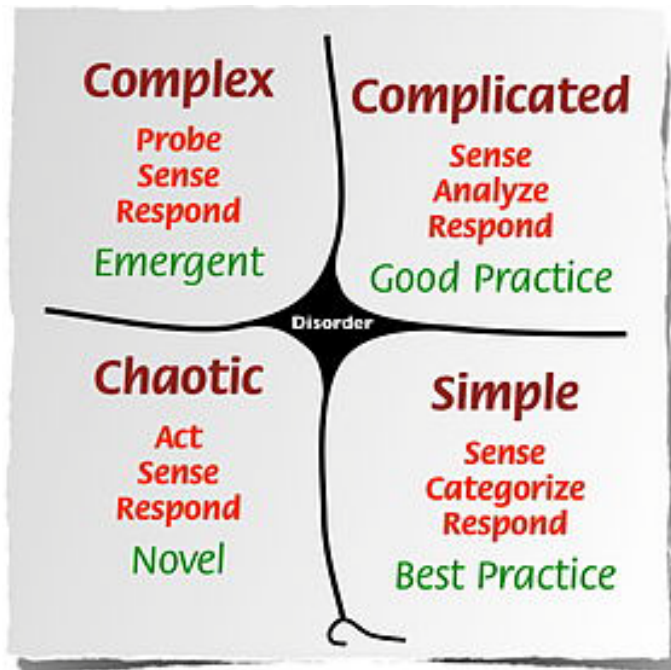
## OGP

Figure 2 – Total Recordable Injury Rate

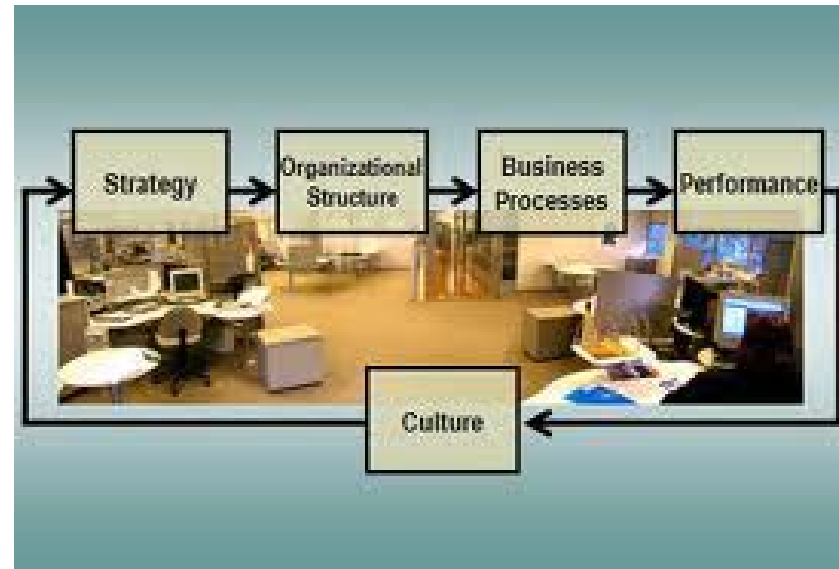
Company and contractor incidents per million hours worked



# To date we have used a strategic management approach to improving safety

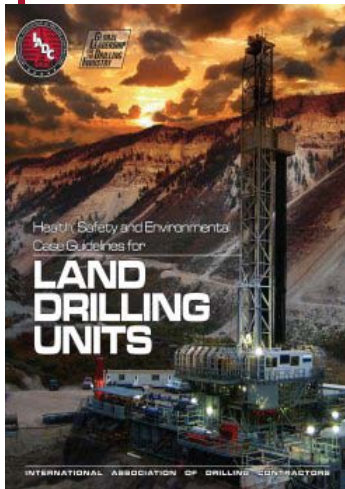


Snowden's Cynefin Framework



.... Is this always appropriate?

# Which has led to a one way dialogue with those at the point of risk ....



## Petroleum and Gas (Production and Safety) Act 2004

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INTERNATIONAL ASSOCIATION OF DRILLING CONTRACTORS  
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### Safety Alert

From the International Association of Drilling Contractors

ALERT 12 - 02

#### DISREGARD FOR ENERGY ISOLATION PROCEDURES RESULTS IN AMPUTATION

##### WHAT HAPPENED:

The service crew was repairing a small 'finger' joint, which had been removed to clear out the water on the horizontal component in the sick room. The supervisor had backed up. Due to excessive slapping motion instead of the forward and back. The supervisor looked at the operator of the pump and said 'back out from the back cover' using a gesture for 'back'. To determine that the pump was back, the finger was engaged and the service crew returned through the normal opening. When it was determined that the pump was operating properly, the service crew returned to put the cover back in place. However, the cover did not slide back into the back cover to re-engage the cover. With the system still running he began to remove the cover, which resulted in his left index finger coming in contact with the rotating pulley and resulting in the losing the tip of his index finger.

##### WHAT CAUSED IT:

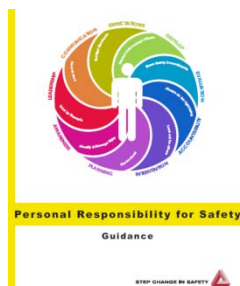
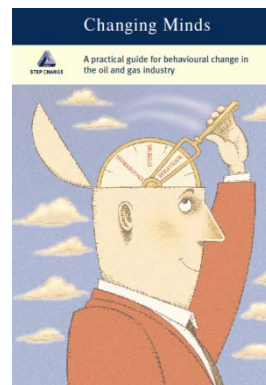
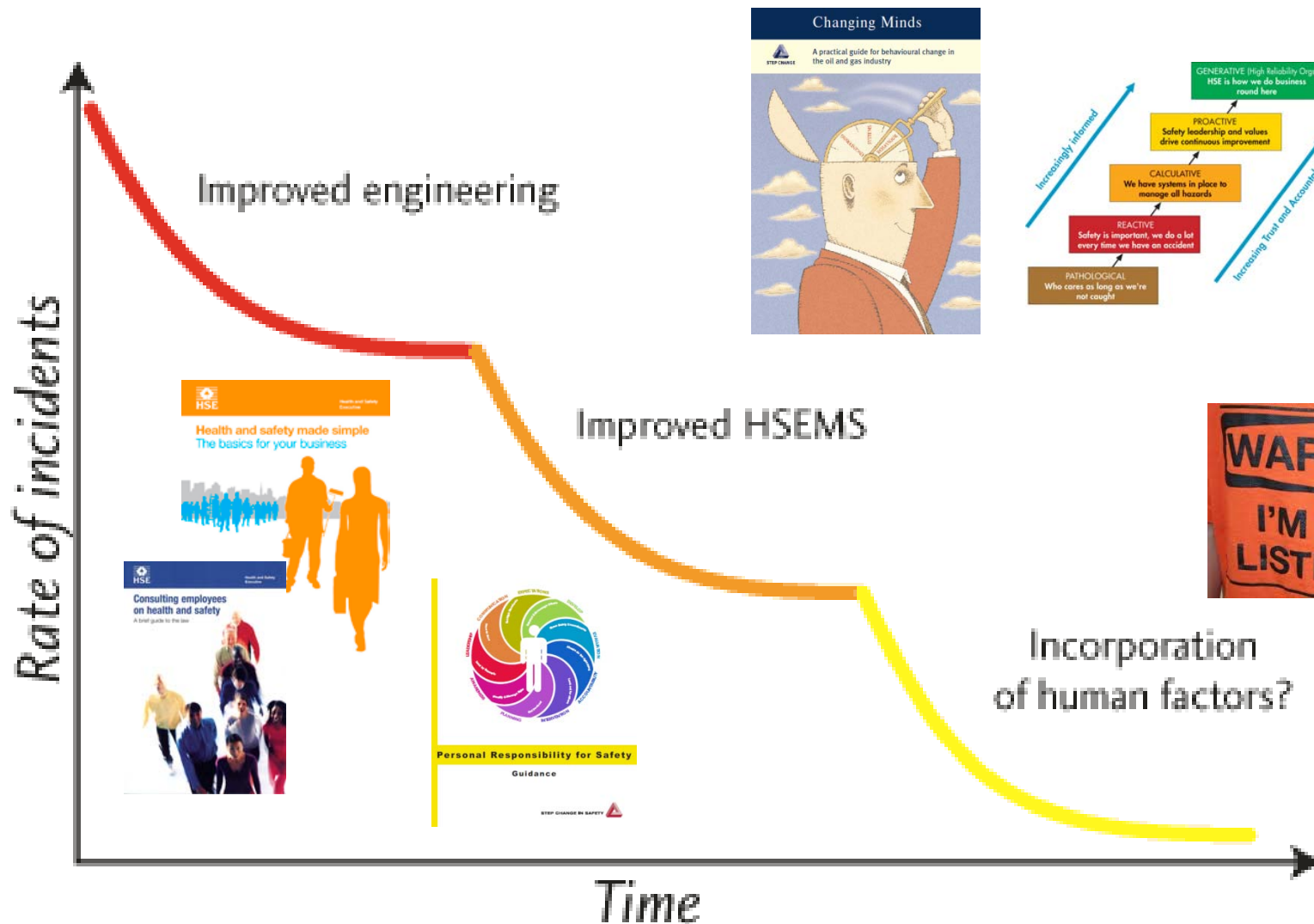
- Improper hand and finger placement when fixing the cover back in place.
- The service crew did not follow the company permit to work and Lock Out/Tag Out procedures in place for the job.
- The cover did not have a handle for the service crew to grip and remove the cover.
- No JSA or Risk Assessment was conducted for the job because no hazard, "we've always done it this way".



The corrective actions stated in this alert are the company's attempt to address the incident, which do not necessarily reflect the position of risk in the entire field community.

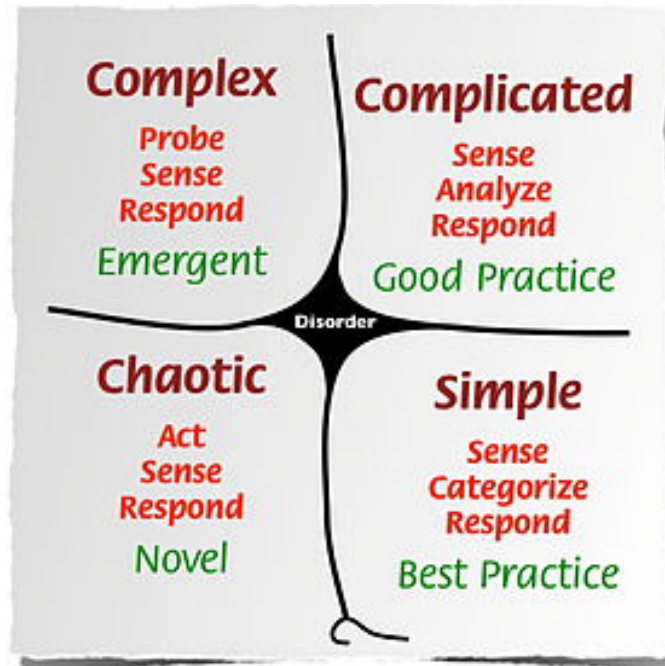


# Insanity: doing the same thing over and over again and expecting different results



Source: OGP

# What if we are in a complex environment?

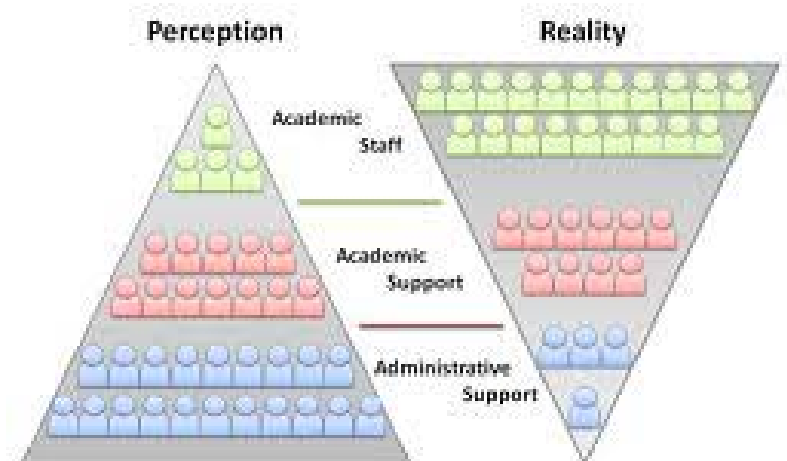


Are we set up to succeed?

# A different approach - Actions driven by the workforce



- Probe
  - Create an environment for experimentation
  - Focus on methods that generate ideas from those with greatest understanding
  - Set barriers
  - Find attractors - things that work for people
  - Encourage dissent and diversity
- Sense
  - Increase levels of communications and connectivity - open up discussions
- Respond
  - Leaders must wait for the path to unfold
  - Make decision connected to those impacted



With thanks to David Kernohan

# Moving to action



1. Provide the right forum for improving communication and decision making, involving:
  - those who understand the issues
  - those who can make the necessary decisions
  
2. Identify key issues that need to be addressed
  - Provide a tool for exploring the issues from a holistic perspective and identifying key actions to be taken
  
3. Mobilise support for the team to execute
  
4. Ensure that you assess the outcome of the action and respond!





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Thank you  
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