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Safety culture

- A safety culture is anything that influences the likelihood of injury or the prevention of injury.

- It is made up of the organisation’s systems, perceptions and behaviour.

- An organisation’s safety culture matures over time and is related to the likelihood of injury.
Safety culture maturity ladder

**PATHOLOGICAL**
- Not Driven

**REACTIVE**
- Avoidance Driven

**SYSTEM MANAGED SAFETY DEPENDENCY**
- System Driven
  - Systems managing health and safety risks
- Continuous Improvement Driven
  - Safety Actively Managed with Workforce
- Value Driven
  - People Driven Safety (Independent-Interdependent)

**PROACTIVE**
- System Driven
  - No Systematic Management of Safety
- Continuous Improvement Driven
  - Safety Actively Managed with Workforce
- Value Driven
  - People Driven Safety (Independent-Interdependent)

**GENERATIVE**
- System Driven
  - No Systematic Management of Safety
- Continuous Improvement Driven
  - Safety Actively Managed with Workforce
- Value Driven
  - People Driven Safety (Independent-Interdependent)
Simple measure of safety culture in organisations

- If you do something risky, what is the likelihood that a co-worker will warn you about it?

- If you do a given task completely safe, what is the likelihood that a co-worker will praise or thank you?
Safety Development

Incidents

Hardware
- Engineering
- Out Hazards

Software
- Systems,
- Procedures,
- Training

People
- Attitudes,
- Beliefs,
- Behaviour

Time

Indifference
Continuous Improvement
Why Behaviour?

• **Attitudinal based interventions tend to have short term effects**
  - Attitudes have a weaker effect on behaviour
  - Behaviour has a stronger effect on attitudes
  - Habitual behaviours are not governed by attitudes

• **Behaviour is driven by the payoffs that result from our actions**
  - Soon, Certain and Positive payoffs encourage unsafe behaviour, e.g. saving time or minimising effort.
  - Delayed, Uncertain and Negative payoffs do not discourage unsafe behaviour e.g. risk of injury or discipline.
The payoffs of behaviour

ILL HEALTH
DELAYED
UNCERTAIN
NEGATIVE

RELAXATION
SOON
CERTAIN
POSITIVE
Behavioural Model

Antecedents
Behaviours
Consequences
Why Behaviour?

- **Basic principles of behavioural psychology provide framework for safety improvement**
  - Activators/Triggers, occur before and set the expectation or need for the behaviour.
  - Consequences, occur after the behaviour and change the likelihood of the behaviour being repeated in the future.

- **Manipulating the Payoffs and Triggers can manipulate behaviour**
  - Positively encouraging safe behaviour
  - Creating avoidance behaviour
  - Discouraging undesired behaviour through punishment
What is behavioural safety?

- A Safety Improvement Process
  - Uses behaviour as performance measure
  - Additional and Complimentary Tool
  - Removes barriers and motivates safe behaviour

- Improving safety communication through BBS fosters a more positive and healthy organizational safety culture and reduces the chances that employees will get hurt on the job.
What is behavioural safety?

• With this in mind, safety culture surveys are used to assess employees’ beliefs and attitudes regarding the culture in their organisation. Certain common theme questions around communication issues are:
  
  ▪ Employees should caution co-workers when they observe them perform at-risk behaviours
  ▪ I am willing to caution co-workers when observing them perform at-risk behaviours
  ▪ I do caution co-workers when observing them perform at-risk behaviours
What is behavioural safety?

• From more than 70,000 surveys given over the last 10 years, approximately 90% of employees agree that you “should” give employees feedback when they are performing an at-risk behaviour.

• Nearly 85% of respondents report that they are “willing” to give correcting feedback when a co-worker is performing an at-risk behaviour.

• Unfortunately, only about 60% of respondents say they actually “do” provide correcting feedback when a co-worker is performing an at-risk behaviour.

‘Using Behavioural Safety to Improve Safety Culture’ – Paper by Joshua P Williams, PhD
Safety Performance solutions
Why this gap?

- If I give somebody feedback about a safety issue, they’re going to get angry. I don’t want to cause problems or get yelled at.
- It’s not my job to give peers feedback. I’m not a supervisor.
- I’ve never given peer feedback before.
- I don’t know enough about that job to give feedback.
- I don’t want to give feedback to someone who has more experience than I do.
- I’m not sure I can give appropriate feedback.
- If I give somebody safety feedback, I’ll be accused of having a hidden agenda.
What is behavioural safety?

- In simplistic terms it’s an observation and feedback process that uses a continuous improvement technique called DO IT

  D – Define critical behaviours to improve
  O – Observe target behaviours to set a base line to set specific goals for achievement
  I – Intervene to change target behaviours
  T – Test the impact of the intervention
The BBS continuum in India

• Supervisory observation which has a disciplinary focus on unsafe acts
to

• a method where you identify some behaviours on a check list, have people go out and start observing them, apply a lot of reinforcements including tangible incentives and then sit back and wait for your incident rate to fall to

• an employee driven model based upon critical behaviours and continual improvement where a ‘bottoms up – top downwards approach’ is followed wherein all frontline staff, supervisors and managers are involved/engaged in the process.
Common stated causes of dissatisfaction

• Narrow scope, focused on behaviour change rather than concurrently addressing causes for at-risk behaviour
• One-size-fits-all approach rather than a BBS system tailored to organisational characteristics and culture
• Poorly integrated with existing safety management systems
• No management commitment
• Lack of belief in its efficacy by the workforce emanating from a lack of awareness/understanding
• Debate between ‘quality’ and ‘quantity’ of observations and how to effectively analyze these
Biggest causes of BBS problems worldwide

Dr Terry E. McSween, Ph.D., Data collected from 70 participants of Behaviour Safety Now Conference 2012
Common causes in India

• Inadequate understanding of BBS and its effect on the safety culture of an organisation

• Failure to translate BBS principles into effective action plans

• Lack of perceived ownership for safety programs that are ‘off the shelf’ and ‘not bespoke enough to make employees own them’ as their own

• Insufficient worker involvement

• Invisible top down support

• Too few champions

• Poor measures of success

• Not recognising the small milestones of success and celebrating them – not adequate positive reinforcement
Process overview: How it works in BG

1. Observation and Measurement
2. Feedback and Trends
3. Behavioural and Root Cause Analysis
4. Implement Recommendations
The six pillars of behavioural safety

- **Management**: Facilitate, Support and Act upon recommendations
- **Ownership & Involvement**: Necessary to maintain involvement and support by employees and Management alike. Goal setting is necessary for continual improvement
- **Awareness Raising**: Employee owned and run process
- **Measurement**: Basic to know progress. Continuously measuring the percentage of safe behaviours.
- **Root Cause Analysis**: BBS is all about identifying the root causes of unsafe behaviours in order to correct them effectively
- **Feedback & Goal Setting**: All members of the organisation are involved. Lack of awareness leads to lack of collaboration

**BBS**
Pillar 1: Awareness

Create Awareness of the process to reduce resistance and encourage participation

- Awareness Leaflets
- Posters
- Presentations
Pillar 2 and 3: Management and ownership

• The Type of Process
  – Top Down (Management Driven)
  – Bottom Up (Driven from Frontline)
  – Collective (Partnership from both levels)
Strengths and weakness of different approaches (1)

• Top Down (Management Driven)
  – Fits well with traditional management +
  – Demonstrates Management Support +
  – Can fail to collect accurate information –
  – Does not encourage ownership of safety -

• Bottom Up (Frontline Driven)
  – Encourages ownership of Safety +
  – More accurate information +
  – Can lead to lack of management support –
Strengths and weakness of different approaches (2)

• Collective (Driven from all Levels)
  – Demonstrates Management Support+
  – Opportunity for partnership in Safety+
  – Transparency of process at all levels+
  – Does not encourage ownership of safety -
  – Potential for management interference -

In BG India this is the model that is now used
Pillar 2 and 3: Management and Ownership

• The Type of Process
  – Top Down (Management Driven)
  – Bottom Up (Driven from Frontline)
  – Collective (Partnership from both levels)

• The Role of Management
  – Need to support the process
  – Visible Management Commitment
Visible management support

• Take full accountability for safety
• Make behavioural expectations clear
• Encourage safe behaviour through recognition and praise
• Immediately address non compliance
• Lead by example, do not work above the rules
• Encourage and empower people to report and intervene without consequences
Pillar 2 and 3: Management and ownership

• The Type of Process
  – Top Down (Management Driven)
  – Bottom Up (Driven from Frontline)
  – Collective (Partnership from both levels)

• The Role of Management
  – Need to support the process
  – Visible Management Commitment

• The Structure of the process
  – Behavioural Safety Champion
  – Behavioural Safety Coordinator
  – Behavioural Safety Team
BBS Organisation: BG India

**Quarterly**
- Asset Safety / BBS Steercomm

**Monthly & Weekly**
- Base (BEST)
- Office (OSCAR)
- Panna (SIMAPS)
- Tapti (REACT)

**Daily & Weekly**
- Site Activities
- Site Activities
- Site Activities
- Site Activities
Pillar 4: Measurement

• Do not record names
• Regular measures that sample the behaviour
• Planned, not just conducted when convenient
• Target one observation per person per week minimum
• Measures should be organised by theme e.g. PPE, Tool Use etc
Advantages of Behavioural Measurement:

1. Prediction of Incidents
2. Combination of Behaviour
3. Free Learning Opportunities
4. Better Tracking
5. Better Understanding

Heinrich Triangle

1 Major
29 Minor
300 Unsafe Acts
### Behaviour Based Safety Observation Checklist

#### Behaviour - Preparation for load lifting

<table>
<thead>
<tr>
<th>Sr. No</th>
<th>Point of Focus</th>
<th>Observations</th>
<th>Safe</th>
<th>Unsafe</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Container door</td>
<td>Door/ hatch closed &amp; secured, Rated for load being lifted</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Correct color coding</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Lifting gear</td>
<td>Visually inspected for damage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Free from sharp edges/twists/ entanglement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Tag lines</td>
<td>At least two tag lines &amp; long enough</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Trajectory</td>
<td>Travel path decided</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Communication system</td>
<td>Hand sign for clear sight</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Plan</td>
<td>Weather parameters are favourable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lifting plan available and discussed with all parties</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lifting checklist filled</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Behaviour - Load lifting

<table>
<thead>
<tr>
<th>Sr. No</th>
<th>Point of Focus</th>
<th>Observations</th>
<th>Safe</th>
<th>Unsafe</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Area</td>
<td>Area barricaded</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Non essential</td>
<td>Non essential persons moved out</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Bank's man</td>
<td>Trained and clearly identified by tacott</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Has clear view of Load &amp; Crane Operator</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Guiding crew</td>
<td>2 persons (trained) available for guiding bulky loads</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Crew not under lift at anytime</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Escape Route clear - not trapped between load &amp; other objects</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Lifted load</td>
<td>Lifts are clear of all obstructions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Load is not left unattended/suspended</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Behaviour - Nonroutine load lifting (permitted activities)

<table>
<thead>
<tr>
<th>Sr. No</th>
<th>Point of focus</th>
<th>Observations</th>
<th>Safe</th>
<th>Unsafe</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>Heavy load (&gt; 7 ton)</td>
<td>Heavy load lifting checklist completed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mechanical person Standby available</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Shaped load</td>
<td>Specific TRA available</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Biped lift</td>
<td>Biped lift done with 2 radians, and PFW</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Plan</td>
<td>Lifting plan available for non-routine lifts</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Remarks

<table>
<thead>
<tr>
<th>Safe operation</th>
<th>Unsafe operation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
A worked example

PPE usage measure

<table>
<thead>
<tr>
<th></th>
<th>Safe</th>
<th>Unsafe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hard Hats:</td>
<td>28</td>
<td>3</td>
</tr>
<tr>
<td>Boots:</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Overalls:</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>Gloves:</td>
<td>23</td>
<td>8</td>
</tr>
<tr>
<td>Glasses:</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Face Masks:</td>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>

\[
\frac{128}{167} \times 100 = 76.6\%
\]
Pillar 5: Feedback

• Aims and objectives of giving and receiving feedback:
  – Motivate by praising safe behaviour
  – Draw attention to unsafe behaviour constructively
  – Identify the barriers to the desired safe behaviour

• Three different methods of feedback:
  – Public feedback (using feedback boards with improvement goals)
  – Team feedback (using regular weekly meetings)
  – Individual one to one feedback (during observation)

• Feedback is most powerful when used with goal setting
Giving feedback

- **Positive**
  - Ideal
  - Fairly harmless

- **Specific**
  - Handle with care

- **Negative**
  - No-go area
Team feedback sessions

- Target people who have not been observed directly
- Conducted on a daily/weekly basis at a regular time
- Structure the session using feedback sandwich
  - Positive findings first (Recognise Effort)
  - Behaviours for improvement (Identify unsafe behaviour)
  - Feedback on proximity to goal accomplishment
  - Issues raised during observations
Individual feedback

- Given immediately when observed, no name or blame to reinforce Just Culture
- The aim of the feedback is to praise what the person has done right and find out why? Unsafe acts are occurring.
- Do not allow bias in perception to impact your feedback
Errors of perception

OLD WOMAN

YOUNG LADY
Golden rules of feedback

• Keep to the behaviour you see, not what you think about the person
• Be tactful, but honest about what you have seen (de-personalise)
• Inform person of what you have observed expanding to potential consequences
• Make the feedback friendly and non threatening (Positive/Improvement/Positive)
• Keep the actual feedback simple and to the point
• Look for information in return (Why? does the behaviour occur)
• Always show respect for the person you are giving the feedback to
Psychology of communication

- Non Verbal Behaviour has a major impact on the message.
Pillar 6: Behavioural and root cause analysis

• A focus on individual behaviour may only lead to short term changes, unless the workplace drivers of unsafe behaviour are removed.

• Understanding Incidents (Causes, Behaviours and Accidents)
Theory of Incident Causation (Reason, 1994)
Causes, behaviours and accidents

Causes
- Production Targets, Workplace Design, Training, Supervision

Behaviour
- Lapses of Attention, Rule Breaking, Violations, Mistakes

Accidents
- Unplanned Events

Fallible Decisions
- Line Management Deficiencies
- Precursors Of Unsafe Acts
- Unsafe Acts
- Incident
- Loss
Behavourial safety and CBA

- Fallible Decisions
- Line Management Deficiencies
- Precursors Of Unsafe Acts
- Unsafe Acts
- Incident
- Loss

Causes
- Production Targets, Workplace Design, Training, Supervision

Behaviour
- Lapses of Attention, Rule Breaking, Violations, Mistakes

Incident
- Unplanned Events

Behavioural Measurement
- (How Frequent?)

Root Cause Analysis
- (Remove Activators/Antecedents)

Pro-Active Intervention
- (Implement Recommendations)
Pillar 6: Behavioural and Root Cause Analysis

• A focus on individual behaviour may only lead to short term changes, unless the workplace drivers of unsafe behaviour are removed.

• Understanding Incidents (Causes, Behaviours and Accidents)

• Need to measure, analyse, identify root causes and implement solutions
Behavioural Analysis (2)

**ABC Analysis**

- **Step 1**: Start Here
- **Step 2**: Identify the causes
  - List Triggers/Antecedents
- **Step 3**: Identify outcomes
  - List Payoffs R+ or R-
Root Cause Analysis: 5 Whys

- Identifies the underlying root cause of the problem
- Ask why? To the problem statement
- Keep asking why, do not develop solutions
- Why? Questions can branch out in several different branches
- Do not develop solutions until root causes have been identified
Developing solutions: Brainstorming

- Define the problem clearly
- Ideas only (no judgement)
- Systematically include all
- Be patient
- Write down all ideas
- Evaluate and build
- Vote
Process Improvement: How it works in BG

1. Observation and Measurement
2. Feedback and Trends
3. Behavioural and Root Cause Analysis
4. Implement Recommendations
## BG India BBS Scorecard: example

<table>
<thead>
<tr>
<th>Theme</th>
<th>Indicator</th>
<th>Unit of Measure</th>
<th>Target 2013</th>
<th>Monthly</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>BG House/Site Committee Meetings</td>
<td>Committee Meeting – Weekly</td>
<td>Nos.</td>
<td>Offshore</td>
<td>Shorebase</td>
<td>BG House</td>
</tr>
<tr>
<td>Trainings</td>
<td>#Train the Trainer’ Batches</td>
<td>Sessions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>*Training for New Observers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>RCA Trainings</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>#Refresher Trainings</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BBS Observations</td>
<td>Total Observations</td>
<td>Number</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Compliance to Accuracy and Consistency Checks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>for new Observers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Area wise % safe Observations</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Driving</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Working at Height</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lifting Operations</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Electrical Safety</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ergonomics &amp; Manual handling</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Housekeeping</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SSOW (PTW)</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Personal Protective Equipments</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Catering</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ABC- RCA Analysis</td>
<td>BBS Root Cause Analyses Approved (Site/Office)</td>
<td>Nos.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Action closeout from the RCA</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Overdue actions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:**
- # - The "Train the Trainer", "Training of New Observers" and "RCA Training" session shall be organised at asset level.
- * - This does not cover projects where there would be separate KPIs as per the HSSE Plan.
## Training matrix

<table>
<thead>
<tr>
<th>Training Type</th>
<th>At Site</th>
<th>At BG House</th>
<th>BBS SC Member</th>
<th>Staff</th>
<th>Supervisor</th>
<th>ALT/ELT Member</th>
<th>Contract (Mode 1)</th>
<th>Contract (Mode 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSSE Induction</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Observation</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Intervention</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>STAR Program</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>RCA</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>MAH for SM</td>
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<td>X</td>
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<tr>
<td>SMT</td>
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<td>X</td>
</tr>
<tr>
<td>Accountability Framework</td>
<td>X</td>
<td></td>
<td></td>
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<td>X</td>
<td>X</td>
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<tr>
<td>Incident Investigation</td>
<td>X</td>
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<td>X</td>
</tr>
</tbody>
</table>
# Training model review matrix

<table>
<thead>
<tr>
<th>What are the barriers?</th>
<th>How will this enable us to improve?</th>
<th>What do we need to do?</th>
<th>What is needed from the Leadership Team</th>
<th>What will tell us if it is working?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability of trainer</td>
<td>Trained personnel will be able to provide quality observation, feedback.</td>
<td>Target to complete a BBS Training Session every month at Offshore platforms to cover maximum POB.</td>
<td>Ø Leadership team should facilitate timely organization of relevant training programs as per calendar.</td>
<td>Ø Number of trained observers, Quality, A&amp;C Checks.</td>
</tr>
<tr>
<td>Mutually acceptable training schedule</td>
<td>Develop better understanding of BBS Process and consequences.</td>
<td>Regular contact programs on each category to create awareness of BBS amongst People.</td>
<td>To follow up for new training modules for Observers, refresher, SC members &amp; RCA</td>
<td>Quality of BBS observation will get improved</td>
</tr>
<tr>
<td>Mobilizing people from platform for attending training from the available crew</td>
<td>Quality of Observation &amp; participation will get improved by new training modules.</td>
<td>Announce schedule of BBS Training and nominate people from each shift</td>
<td>Budget allocation.</td>
<td></td>
</tr>
<tr>
<td>Old training modules &amp; absence of refresher training</td>
<td>BBS concepts will get more understandable.</td>
<td>Revise the modules with lessons learned/success stories</td>
<td>Accountability of line manager to ensure all personnel have undergone BBS training.</td>
<td></td>
</tr>
<tr>
<td>Budget</td>
<td>Understanding and importance of BBS understanding for Safety contribution.</td>
<td>Conduct Refreshing trainings on regular intervals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide flexible venues</td>
<td>MANDATORY TRAINING.</td>
<td></td>
<td></td>
<td>Develop multilingual modules</td>
</tr>
</tbody>
</table>
# Observation, RCA quality and Action Delivery Review

<table>
<thead>
<tr>
<th>What are the barriers?</th>
<th>How will this enable us to improve?</th>
<th>What do we need to do?</th>
<th>What is needed from the Leadership Team</th>
<th>What will tell us if it is working?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of formal Training on BBS and RCA.</td>
<td>Quality of RCA improve.</td>
<td>Ensure A&amp;C checks are done.</td>
<td>Facilitate training sessions on BBS and RCA methodology.</td>
<td>Quality of RCA will be improved.</td>
</tr>
<tr>
<td>A&amp;C Checks not being done on regular basis.</td>
<td>Will enable to eliminate the Root causes unsafe actions.</td>
<td>Conduct trainings.</td>
<td>Support on urgent actions</td>
<td>Improvement in people engagement</td>
</tr>
<tr>
<td>Inadequate time availability and RCA Action tracking review and Close out.</td>
<td>Items required for action close out will be made available and job will be tracked in SAP.</td>
<td>Monthly meetings for RCA follow up actions</td>
<td>Training budget.</td>
<td>Quality of observation improved. Will do relevant RCAs.</td>
</tr>
<tr>
<td>RCA Action tracking points with material requirement are not being converted into SAP MOs</td>
<td>To capture the correct data and conduct the Quality RCAs</td>
<td>Ensure A&amp;C checks are done.</td>
<td>Feedback on RCAs done.</td>
<td></td>
</tr>
<tr>
<td>Quality Observation data is not getting captured</td>
<td>Quality of observation improve</td>
<td>Remove RCA KPI target</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RCA should not be target KPI driven.</td>
<td>Will enable to eliminate the Root causes unsafe actions</td>
<td>SMT Participation in RCA at site</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Lack of formal Training on BBS and RCA: Ensure A&C checks are done. Facilitate training sessions on BBS and RCA methodology. Quality of RCA will be improved.
- A&C Checks not being done on regular basis: Conduct trainings. Support on urgent actions. Improvement in people engagement.
- Inadequate time availability and RCA Action tracking review and Close out: Monthly meetings for RCA follow up actions. Training budget. Quality of observation improved. Will do relevant RCAs.
- RCA Action tracking points with material requirement are not being converted into SAP MOs: To capture the correct data and conduct the Quality RCAs. Ensure A&C checks are done. Feedback on RCAs done.
- Quality Observation data is not getting captured: Remove RCA KPI target.
- RCA should not be target KPI driven: SMT Participation in RCA at site.
Focus on the basics

- Get the BBS Model right and look at a bespoke process
- Focus on awareness campaigns at regular periods to create/reinforce understanding and belief
- Focus Intervention on observable behaviour
- Look for external factors to understand and improve behaviour
- Direct with Activators and motivate with consequence (ABC analysis)
- Focus on Positive consequences to motivate behaviour
- Improve intervention through the DO IT process
- Design interventions with consideration to internal feelings and attitudes
- Review reward and recognition formats to make them more effective
- Formal annual/six monthly review of process and clear action plan to improve
Food for thought

In 2003 there were 100 million occupational injuries causing 0.1 million deaths in the world according to WHO.

It is estimated that in India 17 million occupational non-fatal injuries (17% of the world) and 45,000 fatal injuries (45% of the total deaths due to occupational injuries in the world) occur each year.

Source - ILO Website
Questions?