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| **Supervision** | Supervisors didn’t proactively engage with workers to understand error traps, what makes the work difficult and non-conformances  Over last 6 months there wasn’t evidence that supervisor displayed a range of people skills, built trust, promoted speak up, promptly addressed issues raised by workforce, spent time on the shop floor to understand how the work is really done.  The supervisor didn’t provide adequate job instructions and feedback.  The supervisors didn’t consistently communicate that safety is most important | Supervisors’ roles and responsibilities weren’t clearly defined and understood.  Competence standards weren’t in place for supervisory roles including:   * Technical skills relevant to the process and plant * Non-technical skills (e.g. leadership, managing poor performance, communicating effectively) * Management of organisational performance influencing factors within their control (competence assurance, workload, staffing levels, shift work, fatigue etc.)   Clearly defined arrangements weren’t in place for the supervision of contractors  Arrangements weren’t in place to manage supervisor workload and hours of work to an acceptable level.  There wasn’t evidence of active monitoring / evaluation of the performance of supervisors  Recruitment / Selection and promotion requirements didn’t take into account a range of technical and people skills. | Team members  Supervisors  Supervisor’s line manager  HR person responsible for recruitment, selection, promotion,  Site manager | Review competence standards for supervisory roles  Review documentation relating to defined roles and responsibilities of supervisors  Review performance appraisal documents |  |
| **Operating under changed conditions and Management of Change** | There were similar parts, buttons, valves, levers, gauges etc. that could be easily mixed up and confused with others  Parts of this task changed recently?  This task was performed in an old way  Parts of the task were different from usual routine?  A new tool was confused with the previous version?  Parts of this process were as expected, e.g. valve opens to the left whereas all other valves open to the right  It was a new situation that required improvising or trouble shooting | * Changes of responsibility without adequate arrangements to ensure capability or competence * Reduction in supervision * Team-working deficiencies * Conflicting priorities * Loss of key skills or knowledge * Lack of clarity about important functions and responsibilities * Change of priority away from related tasks * Reduction in available resources for maintenance * Inadequate staffing for handling upsets, crises, or peak workloads | Individuals affected by organisational change (either those affected by past changes / or to be affected by proposed change)  Individuals responsible for the management of organisational change | The management of change policy / procedure the management of change risk assessment records of previously managed organisational changes  documentation which has been modified as a result of organisational change (both previous and current versions) |  |
| **Communication and safety critical information** | Team members didn’t know they supposed to communicate with each other  Team members weren’t in the working area and couldn’t see or hear each other.  Team members did not have common understanding of how to communicate with hand signals.  For safety critical information, e.g. valve numbers operators did not use 3-way communication and phonetic alphabet.  There was no protocol for radio communication in use.  For activities spanning across shifts, there was no written and verbal handover in place.  Language was a barrier  Workers didn’t receive key information from others they depend on, e.g. engineers, planners, safety, customers etc. | Communication techniques weren’t included in the competency system, systematically trained and evaluated  There wasn’t a handover procedure and process in place.  Safety-critical information which needs to be communicated was clearly defined  There were no arrangements in place to monitor, audit and review the transfer of safety-critical information | Operators and other people they communicated with  Supervisor  Competency manager | Review handover procedure, and handover notes.  If radios are used, review if there is a protocol in place and if it was used |  |