SPECIALIST INSPECTION REPORT
Offshore Division Human and Organisational Factors Team
www.hse.gov.uk/humanfactors

Company: Transocean Offshore (North Sea) Ltd

Installations:
John Shaw (Mid-water Floater): 28 -31 July
Galaxy III (High Spec Jackup): 4-6 August
JW Maclean (Mid-water Floater): 23-25 September
Sedco 711 (Mid-water Floater): 5-8 October

Inspected by: Martin Anderson, Specialist Inspector (Human and Organisational Factors), Offshore Division

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Iain Lambie, IMT, Offshore Division (JS)

Purpose of intervention

Transocean is a large duty holder. The 2008 Annual Report of the company states that:

"Our second important achievement of 2008 was successfully integrating the systems and workforces of Transocean and GlobalSantaFe. Transocean now has the world's largest and most technologically advanced offshore rig fleet, not only in terms of total rigs, but also in every rig class in which we compete, including deepwater floaters, midwater floaters and jackups. With a fleet of 136 offshore drilling units plus 10 ultra-deepwater units under or contracted for construction, we are more than twice as large as our next-largest competitor and larger than our next three competitors combined".

In 2008, Transocean reported record financial performance, with net income exceeding $4.2 billion on total revenues of nearly $12.7 billion. As of December 2008, contract revenue backlog was approximately $40 billion.

HSE has become aware that there are significant differences in accident rates between the various rigs; with Transocean's own figures showing a range of TRIR[1] in the north sea between zero and 3.64 (June 2009 figures). Incidents reported to the HSE vary between zero and 15 across 19 rigs, in the two year period 2007-2009.

Now that the organisational changes post-merger with GlobalSantaFe (GSF) have been completed, this is an appropriate time for HSE to review the company's arrangements for health and safety.

[1] Total Recordable Incident Rate, 12-month rolling calculation, measuring how often people are injured.

It was decided to undertake a human and organisational factors intervention on 4 rigs, across a range of safety performance; together with interviews with key onshore personnel.

The aims of this intervention were:

1. To inspect a range of human and organisational factors relating to health and safety;
2. To identify factors that may differentiate rigs in terms of safety performance;
3. To identify any areas for improvement in these issues; and
4. Determine future inspection topics.

Executive Summary

This intervention employed a robust, tried-and-tested methodology which provided a substantial amount of reliable data on which to identify emergent issues and base future intervention strategy. In total, discussions were held with approximately 150 staff, both onshore and offshore.

These discussions (and other sources of information such as documentation) have been analysed and detailed findings are presented in Annex 2, organised under ten key issues.

It was not possible from the data to identify specific issues that may explain the differences in adverse events between the various rigs.

The intervention highlighted a number of strengths within the organisation, including:

1. The company has implemented - and are supporting - several safety initiatives that involve the front line and their supervisors, e.g. risk assessment and safety observations. The THINK initiative, in particular, is a positive initiative and appears to be working well at the sharp end. Supervisors are using these safety initiatives to develop staff understanding of hazards, risks and controls.

2. Staff report an emphasis on training and development – this was reported by many participants as something that the company does well.

3. Transocean has a loyal workforce and has retained many staff with long service. There are many employees who have moved up through the ranks, and so there is a great deal of experience in the company.

4. There is an emphasis on, and support for, Time Out For Safety (TOFS) from all levels of management, on and offshore. More importantly, there is evidence that this process is being used by staff.

5. Undertaking work effectively and safely is a key message.

5. There has been some success in raising awareness of 'people issues' through considerable investment in the 'colours' initiative.

7. Although in the early stages of implementation, the company has recently adopted the Kelvin TOPSET® approach to incident investigation.

3. Details of recent incidents elsewhere in the fleet can be found on various noticeboards around the rigs. These are also more formally communicated to personnel through safety meetings, pre-tour meetings, presentations by the OIM and inductions.

). The company has reacted to recent incidents relating to dropped objects. Stopping production so that all staff could participate in tours to identify potential dropped objects sent a positive message to staff, and was well-received.

Jowever, there are several areas where Transocean falls short of HSE's expectations.

1. The company has not considered the human contribution to safety in a structured and systematic manner. Particularly, human failures and the range of factors that may influence human performance have not been adequately addressed in risk assessment or within incident investigation. The ongoing adoption of Kelvin TOPSET® may increase the profile of human factors in reactive interventions, but further work will be necessary to incorporate the full range of human factors issues into risk assessment (both occupational and major hazard aspects).

2. It is unfortunate that perhaps the most prominent and consistent indicator of Transocean's organisational culture is one of discipline, blame and zero tolerance. Although a culture of leadership, compliance and accountability as an objective is not undesirable, there is an imbalance between the emphasis on management and employee responsibilities in assuring health and safety. Furthermore, the manner by which the desired culture has been communicated to staff has, in some cases, been inappropriate and unhelpful.

   The Accountability process (decision tree) quickly steers the outcome towards individual accountability, with little consideration of wider organisational issues such as fatigue, distraction, communication failures, or defective equipment.

3. Prominent corporate statements, such as those in the Health & Safety and Environmental policies, have an overt emphasis on the roles and responsibilities of employees, focusing on the expectations that management have of their workforce. These documents do not outline in detail management commitment to activities that they themselves will undertake to secure health, safety and environmental aspirations.

4. Adequate supervision complements the provision of information, instruction and training to ensure that the health and safety policy of an organisation is effectively implemented and developed. Effective supervision includes planning, directing, helping, training, coaching and guiding staff. It may also include monitoring performance by formal (e.g. assessment) and informal (spot checks) means. The provision of supervision is a general duty under HSWA 1974. Comments below relate to all levels of offshore management, not just front-line supervisors.

   There are several aspects of Transocean's supervisory and management arrangements which are less than adequate, including:

   a. Unclear expectations of supervisory roles and responsibilities;
   b. Absence of training for supervisors to assist them in training, mentoring and coaching their staff;
   c. Absence of training for supervisors in non-technical (line management) skills;
   d. Absence of training for supervisors in conducting appraisals, or other Human Resources aspects, such as dealing with conflict, identifying symptoms of stress, and disciplinary procedures;
   e. An imbalance between office-based work (such as computer-related tasks, paperwork and meetings) and workplace activities (such as leading and coaching staff, contributing to toolbox talks, safety observations & tours, monitoring work activities);
   f. Being held accountable for the behaviours of their staff should they be involved in an incident, or found to be not complying with policies and procedures, is causing some supervisors considerable stress, particularly if office work is preventing them from being present at the workplace.

5. Unfortunately, unacceptable behaviours by offshore management were raised on more than one rig visited. These behaviours included bullying, aggression, harassment, humiliation and intimidation. OIMs and other managers are perceived to condone such behaviours through their inaction. Staff affected feel unable to raise these issues. Such behaviours are causing some individuals to exhibit symptoms of work-related stress, with potential safety implications. Note that Transocean's general duties under the Health and Safety at Work Act (HSWA) 1974 to ensure the health, safety and welfare at work of all employees would include such considerations.

   The nature of work in the offshore industry and it's traditional 'hard' image does not excuse these behaviours. In addition to being morally unacceptable, such behaviours can lead to poor morale, loss of respect for managers and supervisors, poor performance, lost productivity and absence.

6. The one-a-day START card is perceived by the majority to have devalued the initiative and watered down any real benefits from the process. The comment that "they are not worth the paper that they are written on" was made by several staff. The philosophy behind the process, i.e.

conversations with colleagues to improve safety, is in grave danger of being turned largely into a paperwork exercise, if this is not already the case; with many staff reporting that they simply 'make cards up'.

7. The Health & Safety Policies and Procedures Manual provides a focal point for staff looking for guidance on a wide range of health and safety issues. However, there is a danger that this Manual, and its administration, could take on a life of its own divorced from operations in the field. There are several concerns with this manual and its significance within the health and safety management system:

   a. Hard copies of this manual were not highly visible offshore, other than in the offices of RSTCs and selected supervisors. This is a concern, given the importance on total compliance with its requirements.
   b. Hard copies of manuals seen were all observed to be out-of-date, and staff were generally not aware of a new version on the company intranet or key revisions. Staff working to the old, uncontrolled editions may not be complying with several new requirements in the latest version, including those relating to dropped objects, collision checklists, controlled access to the drill floor - including access diagrams, and TOFS.

8. How management present themselves to their employees is a significant determinant of the 'culture' of an organisation. Senior management (particularly Rig Managers) are not perceived to be visible offshore, and visits are often seen as 'VIP' trips with superficial tours of the rig. There are inconsistencies in (i) how senior managers conduct themselves with the workforce; and (ii) the nature of the key messages that they communicate when offshore, both in their conversations/presentations, and in their behaviours.

9. The training matrix, which drives much of the training function, is not joined-up with the Health & Safety Policies and Procedures Manual (e.g. with respect to Dropped Objects Awareness training). Furthermore, it appears from these matrices that many individuals have not completed the required training for their position or responsibilities (including offshore management, RSTCs and other key staff).

10. The Rig Safety and Training Coordinator (RSTC) position is a key focal point for these issues offshore. However, these staff appear to be heavily involved in administrative activities which limits their time available for training, coaching, undertaking safety tours, and other proactive activities. Furthermore, there is no forum where RSTCs can network, share experiences and support each other.

11. QHSE staff are not perceived to be visible offshore and when offshore are only seen on the day shifts. Many staff with whom we had discussions were unable to name the SHE Advisor assigned to their rig.

12. The QHSE department is perceived by many offshore staff to place unreasonable demands on rig personnel, particularly on the RSTC, rather than be supporting the rig.

13. SHE Advisors and RSTCs do not appear to have an involvement in non-occupational/personal aspects of health and safety; i.e. major hazard aspects.

14. There are relatively few safety representatives; those in post are not actively engaged and meet infrequently – the onus often on the reps to organise themselves. The role itself is poorly described, and staff may perceive that the RSTC function removes the need for safety reps.

15. Several supervisors report that the quality of recent recruits is falling, and this is causing them some concern, particularly as they are 'accountable' for the behaviour of their staff.

Inspector Recommendations & Enforcement

1. I recommend that the complete report be forwarded to the company with a request that a presentation be made within two months of receipt, outlining the company response.

2. I also recommend that the following topics be included in the inspection plans for 2010-12 (to include corporate and offshore interventions):

    a. Supervision (including non-technical skills, bullying);

    b. Training and competence (including the role of the RSTC and on-the-job training systems);

    c. Human failures risk assessment (particularly with respect to major hazard risk assessment; the Safety Case and the Operation Integrity Case);

    d. Incident investigation and accountability issues;

    e. Safety representatives, and workforce involvement.

3. I do not consider that formal enforcement is necessary at this stage.

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ANNEX 1: Intervention approach

Following discussion with colleagues having responsibility for inspecting Transocean, and review of incident notifications and reports, a series of inspection themes were drawn up, building on previous similar interventions. Questions were produced based on these themes and discussed with other members of the intervention team. The findings in Annex 2 are largely structured around these themes.

Offshore inspections
Two inspectors visited four different installations (John Shaw, Galaxy III, JW Maclean and Sedco 711) between July and October 2009. Each inspection team included a Human and Organisational Factors Specialist Inspector, and an Inspection Management Team inspector, with previous experience of Transocean installations.

A range of offshore staff, including third parties, were selected for 'interview'. In some cases, specific individuals were selected by HSE, in other cases (e.g. where several staff had a similar role), HSE selected job descriptions and allowed local management to choose exactly which individual(s) would be selected, in order to reduce the impact of the intervention on operational requirements. In total, approximately 150 staff were involved in the intervention.

Some staff were interviewed individually; in other cases, small groups of staff formed a 'focus group'. Although a structured question set provided the framework, discussions were carried out in an informal and open style to encourage participation and enable staff to raise their own issues and concerns. The inspectors outlined the background to the intervention and explained that anonymity and confidentiality were assured.

Besides the arranged interviews and focus groups, HSE undertook tours around the workplace, taking the opportunity to discuss with members of the workforce more informally; and to e.g. see how safety initiatives work in practice. In all cases, safety representatives were contacted, sometimes leading a safety tour around the installation with HSE.

Other sources of data offshore included notice-boards (e.g. for incident reports, minutes of meetings); procedures, policies, and other safety related information (e.g. PTWs, risk assessments, completed START cards and THINK plans); training records; and information available to staff on the company intranet (e.g. corporate video presentations, details of training courses, news and events, scorecards).

Onshore inspections
A number of senior personnel and members of the QHSE team were interviewed individually over two days. The inspection themes were the same as for the offshore inspections.

ANNEX 2: Detailed Findings

This section outlines detailed findings, structured under the following ten key issues:

1. Human factors 'maturity'
2. Safety initiatives
3. The management of QHSE
4. Accountability and blame
5. Management
6. Supervision
7. Investigations and learning lessons
8. Training and competency
9. Workforce involvement
10. Perceptions of safety

Where quotes are included in the text, the comments (or similar) were made independently by several individuals, and so they represent views of several people.

Issue 1: Human Factors 'maturity'

HSE's model of human factors

1. HSE guidance on human factors – "Reducing Error and Influencing Behaviour" (HSG48, 1999) - introduces key human factors issues that affect health and safety. It describes human factors as having three interacting aspects that impact people's health and safety related behaviour: the job, the individual and the organisation.
2. I would assess Transocean as 'immature' in how it is addressing many aspects of human factors described in this guidance document, particularly organisational issues.

Human factors capability

1. The framework in Offshore Technology Report OTO2002/16 ("Framework for assessing human factor capability") aims to help establish how well an organisation takes account of and manages the human-related issues which contribute to safety.
2. Considering this framework, I would assess Transocean's human factors capability maturity as Level 1: Initial – "Consideration of the human contribution to safety is conducted in an ad hoc, unsystematic way, usually only as a response to specific incidents. In general, these organisations are only beginning to be aware of the need to consider human factors".

3. In particular, there does not appear to be any real consideration of human failures within risk assessment.

Issue 2: Safety initiatives

Two key tools within Transocean's safety management system are the THINK Planning Process and the START Observation and Monitoring Process. These tools, driven from HQ in Houston, have an extremely high profile within the company (e.g. they are referred to in the Health & Safety Policy Statement, the Environmental Policy Statement, newsletters, in communications from management and even on badges sewn onto overalls – "START to be Accountable").

Daily participation in the START process is a corporate KPI and contributes to 10% of the overall rig QHSE score, which itself forms 50% of the Rig Scorecard.

THINK and START are both described in some detail in the Health & Safety Policies and Procedures Manual, and most employees have received training in the use of these tools ("Safety Leadership Training"). Transocean have invested considerable resources in these two tools and they form a significant part of the company's risk management system.

START cards - process

1. The START card process is seen as positive by the majority of personnel.
2. The paperwork and associated training helps staff to approach others on the rig and have the conversations, i.e. the defined process enables and legitimises these conversations, and the subsequent recording of conditions and behaviours.
3. However, many staff report that they find the conversations difficult, i.e. they are reluctant participants, and lack the confidence to approach and challenge staff. Training in this area has not been easily transferred to the workplace for all staff.
4. Staff report that they are concerned about producing a negative START report, as this may result in adverse consequences for themselves, or those whose behaviours they report (i.e. they are concerned about a witch hunt by management to identify and reprimand those involved). This has resulted in a significant percentage of cards completed being positive, or "congratulatory", and may provide a false indicator of actual conditions or behaviours. My perception is that negative cards tend to be related to equipment and conditions; whereas positive cards tend to involve staff behaviours.
5. Management are now reported to have requested more negative cards to be submitted – it has been suggested that this has led to a greater proportion of cards being 'fabricated' (see below).

6. Staff feel being placed between a rock and a hard place – on one hand management are asking for more negative cards, and when these are provided, staff are reprimanded for working unsafely.

START cards – examples inspected

1. Over the course of the four inspections, I reviewed several hundred START cards. There are significant variations in how staff complete the START cards, which makes it difficult to undertake any real analysis on the information recorded. For example:

   a. Some staff circle one or more "S" or "U" on the front page, in order to indicate whether the aspects observed were Satisfactory or Unsatisfactory. Other staff do not complete this section at all.
   b. Where the top section "START Monitoring of the plan" is completed, almost all cards sampled were completed incorrectly. There are six questions under this section – if the THINK plan is still correct, then all but one of the questions should be answered YES. However, question (4) "Are more or less people involved in the task" should be answered with NO if nothing has changed. On almost all cards where this has been completed, staff have answered YES to all six questions. Discussions with staff revealed that they were not aware that question (4) would generally be answered in the negative, as the same number of people were involved throughout the task.
   c. The amount of detail entered onto the cards varies (e.g. "observed galley staff wearing correct PPE while completing tasks").

2. Although significant effort is expended in the process (both in completing the cards and subsequent recording of card data in spreadsheets), there appears to be little real analysis of the information contained on START cards. For example, Transocean do not appear to be analysing those cards reporting conditions versus behaviours, or the actual category of deficiency reported. Staff do not feel that they have received feedback on how they have utilised this safety initiative.

START cards – one card per day

1. The more contentious aspect of this safety initiative is the requirement for all company staff to complete (at least) one card per day. Almost all staff described the START card process as "a numbers game" since this development. Recent Scorecards show that START participation is approaching 100% for all rigs in the North Sea. The figures below are from January to June 2009:

   a. John Shaw 88%, 93%, 98%, 100%, 100%, 100%
   b. Galaxy III 51%, 83%, 100%, 100%, 100%, 100%
   c. JW Maclean 76%, 89%, 100%, 100%, 100%, 100%
   d. Sedco 711 72%, 89%, 97%, 100%, 100%, 100%

2. The messages from Houston and UK management have been received by staff as "it's all about the cards themselves" and "quantity not quality".
3. Many staff commented that this requirement has led to them completing cards after their shift, thinking back to the day's activities. This is not the original purpose of the initiative, where cards would be a record of safety conversations. Clearly, in these cases the conversations are not occurring.
4. Many staff reported that a large percentage of cards are simply "made up".
5. Mobile staff, such as those in mechanical and electrical disciplines, find it easier to produce START cards, as they see a wider range of work activities and workplaces.
6. This is perceived to have devalued the initiative and watered down any real benefits from the process. The comment that "they are not worth the paper that they are written on" was made by several staff. The philosophy behind the process, i.e. conversations with colleagues to improve safety, is in grave danger of being turned largely into a paperwork exercise, if this is not already the case.

START Tours

1. "START tours" (where a small group of staff undertake a safety tour of part of the platform, have conversations with those working nearby, review their risk assessments/method statements/working practices, and record the findings on a START card) appear to have more perceived value by all staff. In these initiatives, the emphasis is on having conversations, giving immediate feedback, and facilitating any necessary improvements – all of which are more in line with the original philosophy behind START.

Written THINK plans

1. This process is perceived as valuable by the majority of staff. It is seen as improving teamwork, getting all staff involved in safety discussions and assessments ("getting the lads to think"), and provides a focus for pre-job Toolbox talks.
2. Written THINK plans include a wide range of hazards and control measures, including personal safety and major hazard issues.
3. Supervisors particularly like this tool, as it helps to explain hazards, risks and control measures to the workforce, in their own language. Rotating who produces the THINK plan is often utilised as a learning and development opportunity. (The Policies and Procedures manual states that "The supervisor is responsible for the quality and completion of the written **THINK** plan" – I'm not sure whether this means that they must complete it personally).
4. Not all respondents perceive this as a team activity, partly because the whole team cannot be released at once to produce and review the THINK plan, due to work commitments.
5. Staff report that they need to do what they write, otherwise they "won't have any legs to stand on if there's an incident". There is a proportion of

employees who perceive this process as a means for management to protect their backs should there be an incident.

5. For some staff, the THINK plans are seen as repetitive, particularly where there is little variation in work activities from day-to-day.
7. In some cases, written THINK plans are not produced due to time constraints – a verbal THINK plan is discussed instead, contrary to the requirements of the Policies and Procedures.
3. Many staff were unaware of the requirement to monitor THINK plans and record this using the top section of the START cards.

THINK risk assessment Prompt cards

1. These cards are well-liked and utilised. They are said to be a useful reminder and are preferred by many to the written THINK plans, given their convenience.
2. As with the written THINK plans, the cards include personal safety and major hazard issues.
3. Staff are aware that they may be asked to demonstrate that they have completed the THINK planning process, and the Prompt card provides a straightforward means of fulfilling this requirement. Several staff were able to produce a completed card at the workplace when requested to do so.
4. The card requires the individual to consider whether the overall risk for the task is Low, Medium or High. If the risk is considered to be Medium or High, then the individual must contact their Supervisor before proceeding with the task. The card itself, and the Health and Safety Policies and Procedures Manual, do not provide any guidance on how to make this assessment. (The LMH risk classification matrix in Section 4, SS2.1, para 4.4 does not relate to the Prompt card).

Shared expectations and the Company Management System

1. Asset and Performance have agreed a set of 14 Shared Expectations (also known as Key Operations Expectations). These expectations are largely safety related and are promoted around the rig (including on continuous rolling display on LCD screens in some galleys).
2. The CMS contains eight management and three behavioural principles, described as the principles that guide people and operations for sustainable success.

Colours

1. There is confusion amongst staff whether this initiative is currently 'live' - some are under the impression that it has been removed.
2. There is no doubt that this process has raised awareness of softer people issues, and the role that these play in health and safety.

3. Staff report that they learned something about themselves - and some reported how they have changed their behaviours following their colours assessment.
4. Supervisors in particular report that the colours initiative has driven them to be more aware of the needs of others, and of the effect that their behaviours may have on their subordinates.
5. However, some staff answered the colours assessment in the way that they would want to be seen by supervisors and management. For example, if one wanted to be promoted into a drilling position, then it would be helpful to have significant attributes associated with the colour "red".
6. Not everyone is comfortable with being 'labeled'. Although the process has some utility, there is a danger that it is over-applied (outside its reliability envelope?) to the extent that the complexities of individuals are reduced to four coloured dots.
7. Some rigs (or at least the RSTCs) had guidance booklets that explain in detail what the various combinations of colours mean; many other staff appear to have a simplistic understanding of the significance of a colours assessment.
8. There are inconsistencies in the underlying philosophy (as it was explained to me) in that the colours are deemed to represent underlying personality characteristics. However, I note that a person's colours may change once they have moved into a new role. There is almost an expectation that this will be the case, and so the colours assessment cannot be describing personality characteristics, as these are generally permanent features.

Time Out For Safety (TOFS)

1. Employees feel comfortable stopping a job and report that this is supported by management.
2. Furthermore, TOFS are not just supported, but actively encouraged by offshore and onshore management.
3. Staff also plan TOFS into work activities, and do not feel that they have to wait until something changes before taking time out.
4. Some staff record that they took 'time out' by completing a START card, although this was not consistent.

'Initiative fatigue'

1. Although individually most of the initiatives are felt to have value, some staff feel that there is too much ("All have value, but it's bogging us down", "too much to take in", "all required by law but head spins").
2. Many staff report that there are lots of safety initiatives and acronyms, and that they are finding it difficult to see "how it all fits together".
3. Several supervisors report that the company is "overloading the guys with bits of paper".
4. Despite the extra work involved in completing safety initiatives, staff report that they have the same job pressures. For example, it is reported that a toolbox talk that previously took 5-10 minutes is now taking up to 30

minutes. Staff feel that they are stuck between a rock and a hard place – they are criticised if they spend too long completing the paperwork, but also if they don't complete the paperwork.

5. Staff have clearly had the acronyms drummed into them, and most staff interviewed could repeat what they mean (i.e. CAKES is Comply, Authority, Knowledge, Experience, Skills etc). However, it is less clear whether all staff understand the principles underlying these acronyms; and whether they are familiar with the relevant aspects of the Policies and Procedures.
6. Senior personnel expressed a concern that these initiatives require significant time from staff, and as the paperwork is completed by hand, questioned the level of 'analysis' or assessment undertaken by front line staff. There is a concern that not only do staff put the minimum onto the paperwork, but they do not have a full discussion of the hazards and controls.
7. There is also a concern from supervisors that if they followed the letter of the law (i.e. the requirements of the 'policy and procedures'), then work performance would suffer. This has led to supervisors taking short-cuts with safety initiatives, such as replacing written THINK plans with verbal plans. Supervisors feel exposed and are concerned about the consequences should this be discovered by management.

Issue 3: The management of QHSE

The role of RSTCs (Rig Safety and Training Coordinators)

1. The role of RSTC appears to be a key position in the company, as a local focal point for both safety and training offshore.
2. RSTCs officially report into the UK HSE Manager, but clearly have to fit into rig operations and initiatives.
3. Most RSTCs were seen to be credible and helpful when approached by staff. They assist staff with THINK plans, PTWs, isolations, TSTPs.
4. RSTCs appear to have very little input into, or awareness of, the MAHRA (Major Accident Hazard Risk Assessment) for the rig.
5. This role is often seen as the 'rig bobby', and is a hard position to fulfill – as they are often seen neither as the workforce's or management's best friend.
6. It is clear that the RSTC position has a demanding workload; and generally, it appears that the philosophy behind the role is not working in practice. That is, RSTCs are spending more time in the office than was envisaged when the role was created. The position is often more administration than coaching, training and supporting staff at the workplace ("they don't get out much, don't see them", "stuck inside – too much paperwork", "don't know what they do all day"). Senior colleagues offshore believe that the role has too much 'policies and procedures' to deal with.
7. There is variation in the activities undertaken by RSTCs, as the role appears to be made by the person in post.
8. The RSTC role appears to have largely replaced safety rep. roles and responsibilities (see Issue 9: Workforce involvement).
9. There is not a formal forum whereby RSTCs can share experiences and support each other. It could be the case that RSTCs are re-inventing the

wheel, when others in the same position may have addressed the same issue previously.

10. RSTCs do not know all of the QHSE Advisors, and have no real correspondence with the head of QHSE. It is reported that they had more support from QHSE prior to the recent merger with GSF.
11. Essentially, RSTCs have very little formal training in health and safety (e.g. such as NEBOSH qualifications). The strategy is to recruit staff into the role with some industry experience (and a suitable personality), and then provide with training necessary to undertake certain aspects of health and safety (e.g. noise training in order to undertake noise assessments).
12. The Health and Safety Policies and Procedures Manual provides no details of the responsibilities or activities of the RSTC position, other than brief references to the responsibility for undertaking or overseeing training on respiratory protection, noise awareness, vibration awareness, manual handling, contributing to worksite evaluations on manual handling and as a suggested member of the QHSE Steering Committee.

The QHSE function

1. The QHSE Manager role is seen as a short-term development opportunity for onshore management; the highest level of technical expertise in health and safety is the UK HSE Manager.
2. SHE Advisors tend to be recruited from the pool of current RSTCs; and therefore, generally have very low education levels in health and safety (i.e. not having NEBOSH certificate or diploma qualifications, or equivalent). Although they have industry experience, and training in discrete aspects of health and safety (e.g. noise, incident investigation, first aid, manual handling, train the trainer), they may not have the full picture of health and safety.
3. SHE Advisors (or RSTCs) do not appear to have an involvement in non-occupational aspects of health and safety; i.e. major hazard aspects.
4. SHE Advisors and RSTCs are described as having a 'very loose' relationship. SHE Advisors report that the majority of the questions that they receive from offshore RSTCs are relating to the company Health and Safety Policies and Procedures Manual, and it is clear that this document is central to their role.
5. The SHE Advisors are not perceived to be visible offshore. It is reported that the SHE Advisors do not travel offshore very often, and are not seen to work nights when offshore. It is considered by staff that they would not know offshore personnel. Many offshore staff were often unable to name the SHE Advisor assigned to their rig.
6. The QHSE department was criticised by many offshore positions for placing demands on the rigs, particularly on the RSTC, rather than supporting the rig ("too many questions and not enough answers").
7. The function is criticised for wanting rapid feedback on issues and questions, placing unreasonable demands on the RSTC in particular.
8. QHSE are considered to dictate policies, rules and procedures to the rigs without first checking that they are fit for purpose. Furthermore, they are said to be telling the rigs what to do, but not helpful in telling them how.

Occupational Health

1. The sole occupational health advisor covers all installations in UK waters. Workload has increased following the merger with GSF.

Health & Safety Policies and Procedures Manual

1. The "Health & Safety Policies and Procedures Manual" includes a description of the company initiatives START and THINK.
2. All staff are reported to be required to read the Manual, and complete a quiz in order to test their knowledge of the contents.
3. This manual was not highly visible offshore, other than in the RSTCs' offices and the offices of selected supervisors/managers.
4. The emphasis on staff following the Policies and Procedures is clear, and has links to the discussions under Issue (4) below on accountability and discipline.
5. Several managers and supervisors on and offshore stated that "all of the policies and procedures are in place, it's just up to the people to follow them now", and "that's all they have to do".
6. We were informed that a new version of this document had been placed on the intranet, but that the offshore workforce had not been informed, which leads to the question of how they will be able to comply. This is particularly key given the new contents included in the latest revision (e.g. with respect to drops, and TOFS).
7. Hard copies of this document inspected on all installations were UK specific manuals dated March 1st 2009; however, the version inspected on the company intranet (not UK specific) was dated August 1st 2009. Those installations inspected after this date (Galaxy III, JW Maclean and Sedco 711) were working to older hard copy versions.
8. The hard copies seen on installations do not include new material added in the August revision (e.g. Section 4, Subsection 2.5 on Dropped objects). For example, the August revision stipulates that: "The **THINK** Planning and **START** Processes must be used to identify and monitor all potential dropped objects".

   Furthermore, this revision requires:

   a. Collision Checklists to be developed for the Driller's control stations and for each crane;
   b. Each area of the drill floor to be designated as one of three zones: Green, Yellow, or Red (the colours reflect who can access the drill floor and what prior risk assessments and training are necessary);
   c. An access diagram to be provided for the drill floor area that depicts all access points as well as the Green, Yellow and Red Zones – and for this diagram to be displayed at each access point to the drill floor area and posted in the driller's station.

d. Additional responsibilities on OIMs and Rig Managers in the reporting of dropped objects.

9. Installations working to the (uncontrolled) hard copies available may not be complying with company policies and procedures on dropped objects. Although the March 2009 version includes some material on drops (S4, subsection 5.3, part 4.9) this does not include the requirements listed above.
10. The August revision to the Manual refers to Time Out for Safety (TOFS) and states that: "A "Time Out for Safety" (TOFS) must be considered as part of the planning process" (S4, SS2.1, 4.3). The description of the THINK Planning Process in the March edition does not include this requirement, nor does this earlier edition contain a separate section on TOFS.
11. Other than brief references to the MAHRA (Major Accident Hazard Risk Assessment), Safety Case and Operation Integrity Case (Section 4, SS2.1, 4.7), the manual provides no reference to the management of major hazard risks. It is largely concerned with occupational, personal safety.
12. There is a danger that Health and Safety Policies and Procedures Manual, and its administration, could take on a life of its own divorced from operations in the field. Concentration upon the development, maintenance and revision of this document centrally may divert attention from practical support to the installations.

Scorecards

1. The Europe and Africa Unit (EAU) Scorecard contains various safety and operational KPIs for the rigs in this region. It provides a snapshot of rig performance in these areas, and traffic light colours enable comparison between rigs at a glance.
2. The position of the four rigs inspected in the April 2009 scorecard (when the intervention was being planned) are as follows (June 2009 position shown in brackets – latest data available). Out of a total of 51 (June 2009: 48) rigs listed:

   a. John Shaw: 51 (bottom position) (48)
   b. Galaxy III: 24 (~middle position) (18)
   c. JW Maclean: 19 (~above middle) (11)
   d. Sedco 711: 11 (top quartile) (1)

3. Health and safety performance is a key contributor to the scorecards (50% of the total rig score).
4. The Scorecard has an impact on Rig Managers' performance pay, and the visibility and profile of the Scorecard ensures an element of competition between the rigs.
5. The scorecards reviewed (six from January to June 2009) show a significant range in both safety and operations performance between the rigs in the Europe and Africa Unit, and between the rigs in the North Sea and Mediterranean (NSM) Division.

5. For the NSM Division, Rig QHSE scores vary between 47.57% and 100%, and Rig Operations scores vary between 54% and 100%[2].

ssue 4: Accountability and blame

Discipline

1. Transocean corporate management aim to "establish a 'zero tolerance' culture on procedural compliance and accountability". A recent company newsletter[3] states that "If people do not perform to a Transocean standard, if they do not comply with our CMS, if they do not live the Core Values . . . . then we are giving some real teeth to the term 'Zero Tolerance'".
2. Furthermore, these communications from corporate management outline the type of culture that they wish to develop: "...creating a strong Leadership, Compliance and Accountability culture in every corner of our company will not be easy and it will not happen overnight". This culture of Leadership, Compliance and Accountability is mentioned in other messages from senior managers[4].
3. Corporate communications also expect "Stepped up accountability responses to PEFs and safety incidents".
4. Personnel on all rigs are concerned that they will be punished should they be involved in an accident ("running people off the rig like it was 20 years ago", "culture of fear", "relief when you get through 12 hours without doing something wrong", "muck up once and you're gone", "one strike and you're out", "zero tolerance policy" and "one thing and you're off").
5. Of all the cultural indicators that I have observed in the company, this is by far the most prominent. It is unfortunate that perhaps the most salient indicator of Transocean's company culture is so profoundly negative.
6. This issue appears to have worsened since the merger with GSF in November 2008. More staff are reported to have received written warnings or been suspended since this merger.
7. "Discipline" is a word that is used frequently by management in their communications with staff. More recently, staff have been informed that if they receive a written warning, they will not be retained by the company when contracts are renewed.
8. Such a culture of fear and blame is undesirable in any workplace. Staff are trying to avoid 'risky' jobs, in case they make a mistake or have an incident - and will then be fired. Furthermore, staff are reported not to be thinking about whether they are working safely, but "if I do this and have a misdemeanor, I could lose my job". ("Our minds are not on the job now because of this").
9. As reported above, staff are concerned about producing negative START cards, as management will attempt to identify and reprimand those involved.
10. The emphasis on accountability is having a direct impact on supervisors, who now understand that they will be subject to disciplinary action if their

[2] June 2009 Scorecard and newsletter
[3] Europe and Africa Unit Newsletter, April 2009 "Creating the Right Culture", article by Rob Saltiel, Executive Vice President, Performance
[4] For example, message from Ricardo Rosa, Senior Vice President, Europe and Africa Unit, EAU Newsletter, June 2009.

staff have an incident or accident. This understanding has been reinforced by Operations Managers. As reported above, this is causing some supervisors considerable stress, as they want to be outside keeping an eye on their staff, but are trapped in the office completing paperwork or attending meetings.

11. This concern is so dominant that staff report being reluctant to be promoted, as they feel that they would be more likely to be sacked (being responsible for the actions of others as well as themselves).
12. Senior management are said to be looking for someone to blame should there be an accident ("pushing the blame offshore"). Initiatives that require more signatures from the workforce (e.g. RMS) are seen as a way of catching up with them should something go wrong.
13. It appears that the company's high-profile compliance and accountability process (including "START to be accountable") is having effects on staff and company culture not originally intended.

Accountability Decision Tree

1. I have inspected the company Accountability Decision Tree (EAU Operations and Performance Procedures, EAU-OPS-PR-01, Figure 1-3-1). The flowchart very quickly steers the analysis outcome towards individual accountability. There appears to be little consideration of wider organisational issues in this process, for example fatigue, distraction, communication failures, or defective equipment.
2. I can find no explanation of the Accountability Process in the "Health and Safety Policies and Procedures Manual (UK Specific)" dated March 1st 2009, other than a definition in the Annex - "Liable for the consequences of an action or lack of action".
3. Section 4, subsection 6.3, chapter 4.3 of this manual outlines the methodology for incident investigation, utilizing Kelvin TOP-SET®. There appears to be no links between this process and the accountability procedure.

Company written policy statements

1. As part of my inspections, I have observed both the "Health and Policy Statement" and "Environmental Policy Statement" to be prominently displayed offshore. Both of these statements place an emphasis on the behaviours of employees (and are almost instructions for employees), and provide very little information on the role of senior managers of the company.
2. For example, the Health and Policy Statement beings: "Management at Transocean is fully committed to conducting operations in an incident-free workplace, all the time, everywhere"; but does not unpack this commitment by outlining how it (i.e. management) will achieve this objective. The remainder of the Policy largely outlines what is required of employees.
3. These prominent corporate statements, with their overt emphasis on the role of individuals, reinforce the blame culture discussed under the discipline section above. Rather than present management commitment, these

documents appear to focus on the expectations that management have of their workforce.

4. Rather than recognising that accidents, ill health and incidents result from failings in management control, and are not necessarily the fault of individual employees, Transocean's Health and Policy Statement places emphasis on individual involvement, personal responsibility and accountability.
5. It is my expectation that such policy statements should outline not just corporate and management aspirations, but also activities that they have (or will) undertake to ensure the health and safety of all staff. For example, the policy statements might refer to all hazards being identified; all risks arising from these being controlled; a commitment to providing the resources necessary to enable safe operations (time, people, equipment, money); providing suitable training and supervision arrangements; to put in place arrangements to learn from experience; undertaking to review and audit all of the above, and perhaps to meet or exceed all relevant regulatory and legislative requirements.
6. In effect, management must demonstrate a commitment to put in place such foundations and infrastructure, that will then enable the workforce to comply with their responsibilities. I'm not in any doubt that senior management are committed to the health and safety of their workforce, but visible indicators such as the written policies emphasise the employees role in this, rather than their own.
7. Key HSE guidance on health and safety management systems (HSG65) provides further details of how companies can set written policies, as required by section 2 of the HSW Act.

Issue 5: Management

Local (offshore) management

1. Generally, responses to questions about offshore installation managers (OIMs) were positive. In many cases, staff felt that they were committed to safety.
2. Unfortunately, undesirable behaviours by management below OIM were reported on more than one rig visited. These behaviours included bullying, aggression, intimidation and offensive language directed at individuals. Staff report being "terrorised" by certain management teams, and several senior managers were described as "having a real reputation". Staff report that they "cannot relax with these two on" and that "there's a dark cloud on the rig when these two are on". Some senior supervisors are aware that they can have "red-red moments" (referring to the colours initiative).
3. OIMs are perceived to condone such behaviours, by observing it and not taking any action.
4. In the past, OIMs and Toolpushers were considered to have the rig's best interests at heart. That is said to be changing, and these positions are now reported to have less loyalty to the rig (some staff reporting that they care for themselves, not the lads).
5. OIMs and Senior/Day Toolpushers are considered to have too much paperwork and attend too many meetings, which is reducing their

accessibility and visibility at the workplace ("OIM gets so many emails some days, he doesn't get outside").

6. Other managers and supervisors spend a great deal of time working on computers, rather than at the workplace.
7. Staff report that some pairs of OIMs have very different approaches and may contradict each other (e.g. one wanted a procedure before signing a PTW, another did not require this).
8. Management are said to be very good at picking on negative points, with little positive encouragement. It is reported that if staff perform well 99% of the time, they are reprimanded for the 1% of the time that they do not - perform as expected. Staff report that they never get told that they have done a good job, and that "there is only so much negative that they can take".

Senior management (onshore)

1. There is high-level corporate commitment to health and safety; for example, as described in the 2008 Annual Report: "Our goal is to have an incident-free work environment all the time, everywhere, and we will continue to do all we can to achieve this goal".
2. Offshore staff are generally less positive about onshore management than they are about local offshore management.
3. It has been difficult to summarise staff perceptions of the onshore management team, as there is a wide variation in responses from staff.
4. On one rig visited, the comments were particularly negative. The Rig Manager is described as inexperienced, and a recent visit to the rig was consistently perceived by a wide range of staff as particularly unhelpful. On this visit, a town hall meeting to staff "shattered morale" and was very threatening - "other people are waiting for your jobs" (if you do not follow rules and procedures).
5. Offshore personnel were of the opinion that the majority of senior management are ex-GSF, and are described as having a culture of sacking staff if they do not comply with procedures.
6. On one rig, we were informed that staff would rather have a visit from HSE than onshore management, and this comment was said to indicate how disliked management are.
7. On other rigs, the Rig Managers are seen in a more positive light (e.g. a recent visit by one with the Senior Operations Manager was helpful, and were seen as open and good for morale). Both Rig Managers for this installation are described as approachable and an improvement on previous managers.
8. Messages from Dave Walls in particular were very positive - several staff reported him saying it's key that people do not get hurt, and that they are more valuable than machinery, which can always be replaced. This message was much appreciated and indicated to staff that management did care about their safety.
9. There are inconsistencies between rigs as to how often senior managers (particularly Rig Managers) travel offshore and their offshore activities. Some are described as making "VIP" visits – out on Tuesday and back on

Thursday – and only making superficial tours of the rig. The lack of visibility offshore was a frequent comment, especially in relation to helping to launch safety initiatives. Some Rig Managers informed us that they aim to visit the rig once per month, and find this a challenge.

10. Some Rig Managers are reported to be approachable and said to conduct useful START tours, whilst others are reported to not wish to talk to anyone below Driller level when conducting a tour.
11. Staff feel that they never really get visits from 'bigwigs' – unless they experience an incident, "when they come offshore to tell us how sh*t we are".
12. Similar to the comment from staff on negative feedback from offshore management, staff reported that "Nothing positive has come from management" (referring to feedback).
13. As part of the inspection, I reviewed several DVD presentations by corporate management executives based in Houston. One of these emphasised Policies and Procedures, stressing compliance (see Issue 4 above), and reinforced the Leadership, Compliance and Accountability culture that many staff perceive as negative.

Changes to management

1. On one of the inspections, the OIM arrived on the rig with HSE for his first trip on the installation. It was noted that the Senior Toolpusher was also new this tour. Questions were raised by staff at all levels on the nature of the handover and preparation, particularly as to whether the incoming OIM would be able to respond appropriately in the event of an emergency.
2. This rig had experienced a very recent change of Rig Manager as well as the OIM. Many staff reported that this was their third Rig Manager in twelve months – and there were various rumours as to why this was the case.
3. The company is reported to have lost 5 Rig Managers within a short space of time, creating a vacuum and this led to some rapid promotions (see below).

Corporate issues and complexity

1. The vast majority of staff, from all rigs and at all levels, considered that the company has become too big and that "you're just a number".
2. Staff find it difficult to find out who does what in Aberdeen. They do not know people in the office since the merger, and consider that few people in the office would know who they are.
3. Some personnel consider that "two cultures of safety and production are colliding" – reporting that since the merger, there has been lots of emphasis on production, but management want good safety performance at the same time. Some staff feel that these two goals are incompatible.

Promotion

1. Clearly the company has been able to retain staff over many years; and there are numerous examples of senior staff having worked their way up the ladder from entry-level positions.
2. Many staff report that the largest jump in terms of promotion is from Assistant Driller to Driller.
3. On one rig, the Senior and Night Toolpushers and Driller were all recently promoted and said to all be "learning on the run". Although these personnel may have been experienced in their previous roles, there seems to be little recognition that the new role may be quite different, with little support for the new aspects.
4. Some staff report that although guys are being promoted quicker than before, the quality of training is not as good (see Issue 8).
5. Staff not pushing for promotions are reported to be blocking those below them from moving upwards also, as opportunities are not opening up.
6. Support and mentoring for senior onshore staff is not well-developed; this is compounded by promotions onshore being rapid in some cases. The merger with GSF is reported to have reduced the support network available to Rig Managers.

Issue 6: Supervision

1. Adequate supervision complements the provision of information, instruction and training to ensure that the health and safety policy of an organisation is effectively implemented and developed. Effective supervision includes planning, directing, helping, training, coaching and guiding staff. It may also include monitoring performance by formal (e.g. assessment) and informal (spot checks) means.
2. HSG65[5] states that "Although authority to act can be delegated to supervisors and employees, the ultimate responsibility for complying with the employer's legal duties cannot be delegated. It follows that management must ensure that those exercising discretion and judgement are competent to do so and have clear guidelines".
3. As part of my inspections, I have watched several videos from Transocean corporate management. The presentation by A Bobillier (Executive VP, Asset Management) on accountability refers to an earlier DVD presentation by Steven Newman, COO. Mr Newman is reported to have stated that *"leadership is not about position, but about how people do conduct themselves, while fulfilling their responsibilities. He also added that supervisors must coach and mentor their people"*[6]. However, I am not aware of any training or support currently or recently being provided to supervisors and managers to assist them meeting these expectations.
4. The majority of supervisors interviewed were not able to clearly outline expectations set on them by the company.

[5] Successful health and safety management (HSE, 1997), ISBN 978 0 7176 1276 5
[6] A Bobillier presentation, 00min 16secs

5. Several supervisors expressed concern that they are in charge, this being the first time that they have had to manage people, with no skills or training to support them in this role.
6. Staff at all levels outline the amount of training that has been undertaken, however, Transocean apparently provides no training or support in non-technical skills for supervisors.
7. Current high-profile training (Safety Leadership Training – SLT, and Safety Leadership Foundations - SLF) do not appear to provide suitable training on these non-technical issues. (SLT is described by the company as "the training tool used throughout the company to teach and re-enforce the correct use of Transocean's safety tools in innovative ways with group and individual training components" and is based around the THINK and START systems[7]). Furthermore, third parties are not part of the Transocean training matrix system and so would not receive such training.
8. A key aspect of supervision is the training, mentoring and coaching of staff. I could not identify any training that supervisors had received to support them in this key role, such as 'train-the-trainer' training.
9. Supervisors report that they "build up the skills over time" and "watch how other people manage and learn from them" (e.g. two staff noting how well Dave Walls was received offshore). Some staff will undoubtedly gain experience of supervising staff as they move through the ranks, however, this experience is not structured or formal.
10. The 'colours' initiative is said to assist with these aspects, for example by 'treating people as they need to be treated'. Staff were less clear about the actual practice behind this mantra. Furthermore, the 'colours' assigned to an individual are solid state, or static, whereas in reality people's lives change (e.g. births, deaths, marriages and mortgages).
11. Supervisors who are responsible for conducting staff appraisals report having no training for this key process.
12. Furthermore, supervisors do not appear to have received training in other HR issues such as identifying the symptoms of stress, dealing with conflict, and discipline.
13. Many supervisors report a dilemma – increasing paperwork ties them to their offices; however, they are increasingly aware that they will be held accountable should any of their staff be involved in an accident, and therefore feel the need to be outside more. This issue may be causing some supervisors unnecessary stress.
14. Those supervisors who do get outside and monitor the job may be doing this despite organisational arrangements.
15. In summary, the company does not appear to be providing supervisory staff with clear expectations of what is required of them, nor the time or training to effectively discharge their responsibilities. This is a concern given the importance of these roles.

[7] www.deepwater.com/fw/main/safety-leadership-training-564.html

Issue 7: Investigations and learning lessons

1. I note that the March 2009 and August 2009 editions of the Health and Safety Policies and Procedures Manual state that "The Company approved incident investigation methodology is Kelvin TOP-SET®. All incidents must be investigated using this methodology" (S4, SS6.3, 4.3).
2. At the time of the intervention, selected personnel had received training in the Kelvin TOPSET® incident investigation methodology. I understand that this tool and training will be provided to all RSTCs and key supervisors/managers, who will undertake a 3-day investigator course to equip them as Lead Investigators. I understand that all other personnel may undertake a 1-day course.
3. This is clearly a new initiative and very few staff interviewed were familiar with it, or had actually undertaken TOPSET® training.
4. It appears that the requirements outlined in the Policies and Procedures have preceded the implementation of this initiative – making it very difficult for staff at all levels to comply with the requirements.
5. Current (i.e. prior to adoption of TOPSET®) incident investigation appears to have been variable; a senior offshore worker questioned the competency of investigation teams.
6. There were many comments by staff that there was too much investigation into what appear to be small incidents ("big fuss over nothing", "going over the top").
7. Newsletter January 2009 includes an outline of the reporting process for High Potential Dropped Objects. This process requires the on-site supervisor and their immediate supervisor to both forward personal notes to Steven Newman (President and COO), including what happened and how this was accounted for in the planning – and how the supervisor is going to improve his own leadership skills and the teams' risk assessment skills to prevent a recurrence. These notes are to be completed within 24 hours and copied to a range of senior management including EVPs, SVPs and senior QHSE personnel.
8. Details of recent incidents elsewhere in the fleet can be found on various noticeboards around the rigs. These are also communicated to personnel through safety meetings, pre-tour meetings, presentations by the OIM and inductions.
9. Lessons from incidents are entered into GRS (Global Reporting System) and are tracked to completion.
10. Staff on rigs with higher rates of incidents have suggested that they have a higher reporting rate than other installations, and suggest that some rigs may not be reporting all incidents.
11. Incident reporting is related to the Accountability and blame issue above – staff comment that the approach taken by management in response to an incident is affecting reporting rates, such that some events go unreported. This would be unfortunate, as the company wishes to learn from incidents in order to prevent recurrences.
12. The company has a corporate auditing process known as PMAA (Performance Monitoring Audit and Assessments). There is a programme of PMAAs in the North Sea; offshore staff perceive this to be an important initiative and are extremely keen to receive a satisfactory score.

Issue 8: Training and competency

Training records

1. I reviewed training compliance or discrepancy reports on several rigs. These are usually posted on notice boards.
2. The training matrices have not been updated to take account of changes to the Health and Safety Policies and Procedures Manual; for example, the August 2009 revision requires 'Dropped Objects Awareness' training for all company personnel, but this was not included on the matrices inspected.
3. These documents appear to show that many individuals have not completed all of the required training for their position or responsibilities. For example, on one installation:

    a. Compliance with "BOSIET" was 77.27% (20 staff were not compliant);
    b. Compliance with "UK incident Inv. & OJT" was 25% (3 staff were not compliant, including both OIMs and an RSTC);
    c. Compliance with "Well Control" was 62.5% (6 staff were not compliant, including both OIMs, both Toolpushers and assistant Driller);
    d. Compliance with "Rig Medic" was 50% (1 member of staff – Medic – not compliant);
    e. Compliance with "Scaffold Erection & Inspection" was 10% (9 staff were not compliant, including both RSTCs);
    f. Compliance with "Dangerous Goods Handling" was 17.86% (23 staff were not compliant);

4. Staff report that they attend training in no particular order; whereas it might be more productive if key staff and supervisors attend training courses first, so that they can support their staff when they undertake it.
5. Staff report that training is not tailored, for example, they all attend SLT and SLF in mixed roles and capabilities – it was suggested that these and other courses could be tailored for supervisors and other staff, as they might have different training needs.

Competency

1. Many staff raised the issue of training being undertaken during their time off. Even though the training is paid, many staff feel that the company do not respect their time off at all. Depending upon where staff are based, training during this time could have a large impact on their rest breaks. Some staff report that they have not had a full trip at home this year. Concerns are further increased by OIMs perceived to be undertaking training and seminars in rig time.
2. It was suggested by some staff that more training could be undertaken in rig time, and their positions covered by staff from stacked rigs.
3. Moves from external training providers to Transocean-provided training is seen by the workforce as a deliberate move by management to provide

training that is not accredited or accepted elsewhere (as a way of retaining staff who do not have 'portable' qualifications).

4. Some employees are concerned that when they have received training on a subject, they are then considered to be competent on it (whether they feel so or not), and so will be blamed should they do something incorrectly, or lead to an incident.
5. It was stated that there is no training once staff are promoted above Driller level. There appears to be little recognition that the Driller and Toolpusher roles are considerably different; and there is little support for this change of role. This reinforces the view that training is focused on technical skills, rather than management or non-technical skills (see Issue 6).
6. Several supervisors stated that the quality of new recruits is falling, to the extent that they need to be told more, step by step; and have to be told simple things several times ("not sure how they complete the Prompt cards on their own. . . ").
7. Supervisors feel that they need to be present all of the time ("especially with the people they send out nowadays", "wouldn't even employ them in Asda", "Wonder how some of them get dressed by themselves in the morning"). This is related to the accountability issue (see Issue 4) – as supervisors are considered to be more accountable for the actions of their staff.
8. The On-the-Job Training (OJT) is reporting as working well for some staff, for example, one NTP outlined how he assesses the Driller and Assistant Driller, using company guidance for assessors.
9. Although there is a system for OJT, some staff have been on the drill floor for two years, but do not feel trained or confident. The company would argue that they are experienced, but they do not feel that that is the case.
10. NRB (Not Required Back) has been an issue in the offshore industry generally, but some supervisors state that it is "now very difficult to get rid of unsuitable people".
11. Given that several rigs are currently stacked, if staff are lost, then when the economy improves, the company may be restarting with many green hats.

Issue 9: Workforce involvement

Involvement

1. There are relatively few safety representatives, with several crews lacking representation.
2. RSTCs find it difficult to both recruit and engage safety representatives.
3. Safety reps are not actively engaged in incident investigations; may not be provided with copies of accident investigation reports, and have not seen letters from previous HSE inspections.
4. I note that the safety rep function or activities are not mentioned in the Health and Safety Policies and Procedures Manual, other than as suggested members of the QHSE Steering Committee.
5. Clearly, if safety reps are required to undertake further training in their own time, and then they are not being utilised, it is understandable that few volunteers are coming forward for this role.

6. Many staff feel that the RSTC role removes the need for safety reps. The safety rep. role appears to be poorly described, and staff are not clear as to what they would be signing up for. Further defining the role, or perhaps involving staff in short-term 'projects' with less commitment may produce more volunteers.
7. Generally, safety committees do not meet regularly. On one installation, the most recent safety committee meeting was 5 months ago.
8. The onus appears to be on the safety reps to organize themselves (e.g. comments that "they have been given the 971 guidelines, but have not held many meetings").
9. Several members of the workforce commented that their skills and experience are not valued, that their opinions are not sought and they do not feel involved.

Teamwork

1. All rigs inspected reported that teamwork was good ("10 out of 10 for teamwork" and "work well together").
2. There does not appear to be a "them and us" culture – either between the workforce and management; or between staff employees and third parties.

Issue 10: Perceptions of safety

Pressure

1. Some staff report that, previously, it was a case of getting the job done regardless ("why are we waiting", and "go, go, go").
2. However, it is considered to be better now that they have the various safety tools, including THINK, TOFS and Prompt cards ("it's less gung-ho").
3. The culture is also described as being better now that certain staff have moved on.
4. Despite some reports of less 'production pressure', many staff do feel overwhelmed ("Transocean add & add, but take nothing away").

Perceptions of safety

1. Staff generally reported that they felt the rig was a safe place to work (despite the relatively high incident record on some installations).
2. Comments were made that the rig is getting safer, that the safety initiatives are useful, and that the rig is now "better controlled".
3. Employees feel proud of the rig and feel let down if they have an incident.
4. Some comments were made regarding the number of hours worked without an incident on other rigs – and how this can be possible in undertaking physically demanding manual activities. The suggestion was that staff on some rigs are not reporting incidents, which is making those rigs that do report events appear to be worse (see Issue 4).

Morale

1. This will obviously be influenced by length of contract remaining – those staff working on rigs with long contracts are feeling more secure.
2. Younger staff who have not previously experienced a downturn in the industry are more uncertain than other staff.
3. Morale is generally low at the moment, and is described as "taking a dive" recently.
4. People are "keeping their heads down", fearing that if they do not follow procedures, instructions, or have an incident, then they will be sacked.
5. The focus on discipline, suspension and sacking is affecting morale and especially for those with young families and large mortgages, it is said that "some people's minds will not be on their jobs".