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HSE LEADERSHIP THAT WORKS

Demonstrable control in the field

From risk analysis to a decision that holds.
For HSE professionals, project managers and supervisors

 LEADERSHIP RISK MANAGEMENT STANDARDS COMPETENCES CONTROL

PREPARE • PREVENT • PROTECT



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CHAPTER 01 • SAFETY ON PAPER VERSUS SAFETY IN THE FIELD

Why a correct system does not guarantee safe execution

THE PERMIT WAS IN ORDER

Quarter to six. Three men at a product line. Opening a flange, the same job as four times earlier this year. The coffee is still hot. The schedule is already under pressure.

The permit to work looks exemplary: scope, isolation, depressurisation, signatures. Issued last night, along with eleven others. On paper the crew can start. Unfortunately, the supervisors have not read that paper.

Three things have changed since it was issued. None of them has been reviewed again with the crew.

The night shift reopened a valve to drain product elsewhere. It is in the logbook. The day supervisor reads it, but does not link the other tag number to this permit. Everyone holds one piece of information. Nobody checks the whole isolation route for this task.

The scaffold has been moved. The crew now works half a metre closer to the flange. The exposure has changed with it.

The regular pipefitter is ill. His replacement knows the trade and has the certificates. He does not yet know this installation. That difference disappears easily behind the reassuring word 'competent'.

Three changes. Three reasons to reassess the release. On the form, everything stays calmly green.

The flange opens. Product comes out. The replacement happens to be standing to the left of the outflow: from the moved scaffold he could not reach it any other way. No injury. So the daily report can say again that it went well.

Ending well is something quite different from being well controlled.

I have seen files where the risk analysis was in order, the instructions signed and the training matrix green. All green. And on site a crew was working on a line that nobody could point out where it had been isolated. Green in Excel and dry in the field are two different states.

Why this chapter matters

As a prevention adviser I want to know what actually protects a crew. A tidy folder tells me that somebody made a folder. Only at the installation can I see whether the agreements hold when production and the contractor are both in a hurry.

Here is the trap: everyone treats their own piece as finished. The permit is signed. The logbook is filled in. The replacement is authorised. But nobody connects the change to the barrier these people need right now.

On your next round, by all means ask about the procedure. Then walk to the place where it has to work.

Ask there: 'What energy could be released here? What stops it? Who checked that for this task?' Without a critical barrier that demonstrably works, the task stays stopped. Even when the schedule turns red.

That is where HSE leadership begins: getting the uncertainty on the table before anyone loosens the first bolt.

What you will be able to do after this book

Make the next ninety days concrete. Use these five results as a work agenda, each with an owner and evidence:

For each high-risk task, name the critical barriers. Describe how they can fail and record how you check that they work.

Check at the work location that scope, isolations, crew and surroundings still match the permit to work.

Investigate an incident beyond 'procedure not followed'. Find out why that choice seemed logical. Which barrier failed? Then speak to the person who can change the circumstances.

Put a reasoned choice to management: which scenario do we control, which evidence is missing, what does recovery cost and under what conditions can the work continue safely?

Make sure you can trace your advice, the decision, the execution and the verification. With names and dates. Even months later.

That last point deserves more attention than a tick that says 'discussed'.

The four classic gaps between system and execution

Four gaps. You recognise them faster when you stand next to the crew.

1. Work as imagined versus work as done

On the schedule everything fits. At the work site there is a container in front of the access, the new crew speaks another language and the contractor asks whether it can be squeezed in 'quickly'. Yesterday's risk analysis does not know this version of the work.

In our case the scaffold stands differently. That changes the working posture and the distance to the outflow. The escape route may be different too. A small move on the drawing can be a big change in exposure.

Ask the crew what they have to adjust to make the plan workable. Listen before you correct. A detour can point to a badly designed task. Have the access and isolation reassessed. Does the chosen work method still fit this situation?

2. Administrative checks are confused with risk control

A signature is useful evidence of a decision. It is not a shut-off valve. You cannot close a line with it.

At the permit desk the contractor is waiting. The manager hears 'everything checked' and signs. Five seconds gained. Except: who means the complete isolation by 'everything', and who means the boxes above the signature?

TOOL A • PSS five-minute field scan

Is this task demonstrably under control right now?

During preparation, execution or a relevant change. Five minutes is a conversation rhythm, not a time limit for investigation. The scan does not replace a full risk analysis or release.

Task, location and moment What is being carried out now, where and by whom?

Energy and exposure Which relevant sources can hit whom, including through linked activities?

Critical barrier and evidence What must work? Note the test method, result, validity and missing evidence.

[Back to the explanation in Chapter 17](#)

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If the answer does not fit, use a numbered annex with tool code, field name and date. Refer to it. Split long codes where needed and, before sharing or printing, check that all text is visible.