Lessons Learned Template

Ideas for the Presentation of Lessons Learned Material

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**Summary of the Incident:**

- Activity: e.g. Lifting or Working at Height
- Loss: e.g. DAWC
- Immediate Causes of Incident: e.g. Operation at excessive speed
- Location of Incident: e.g. Onshore Site X / Offshore Platform Y
- Date of Incident: - - -

**The Themes of this Lesson:**

- e.g. Personal Positioning
- e.g. The importance of Pre Job Planning
Description of the Work:

On [date], at approximately [time]
Describe what was going on prior to the incident
The driver of a truck was [e.t.c. (see sketch below)]

Sketch Pre-Incident

Note the position of the Start of the Job on the Time Line – post System Failures

Start of the Job
[Time/Date]

Time of the Injury
[Time/Date]

“Personal Injury”

Note much the information related to this incident has been deleted or adjusted for confidentiality reasons – it is given purely for illustrative purposes only.
## Description of the Work:

On [date], at approximately [time],
Describe what was going on prior to the incident:
The driver of a truck was [--- e.t.c. (see sketch below)]

## Description of the Incident:

Describe what happened:
As the skip was being lifted, it caught the side of an adjacent skip and [--- e.t.c. (see sketch below)]

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**Sketch Pre-Incident**

![Pre-Incident Sketch]

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**Sketch Post-Incident**

![Post-Incident Sketch]

Add any photographs to illustrate position of people & equipment.

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Note the position of the Start of the Job on the Time Line – post System Failures.

Start of the Job:
Time: [--- Date]

Time of the Injury:
Time: [--- Date]

"Personal Injury"
Incident Investigation Analysis Summary Example v The Time Line

**Historical Unsafe Acts:**
1. The equipment was placed too close together during a previous lifting operation by the X.
2. Site supervision failed to control the proper placement (relative positioning) of equipment.

**Critical Factors:**
1. The man was in a position of danger (wrong position) in relation to ____________
2. The equipment was too close together ______
3. The driver commenced the lift ______

**Unsafe Acts (Immediate Causes)**
1. Improper work position by X for the task.
2. Improper lifting by Z—he should have made an assessment of the lift before proceeding.

**Unsafe Conditions (Immediate Causes)**
1. The equipment was physically too close together.

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Incident Investigation Analysis Summary  Example v The Time Line

**Critical Factors:**
1. The man was in a position of danger (wrong position) in relation to 
2. The equipment was too close together 
3. The driver commenced the lift 

**Historical Unsafe Acts:**
1. The equipment was placed too close together during a previous lifting operation by the X
2. Site supervision failed to control the proper placement (relative positioning) of equipment

**Unsafe Acts (Immediate Causes):**
1. Improper work position by X for the task
2. Improper lifting by Z—he should have made an assessment of the lift before proceeding

**Unsafe Conditions (Immediate Causes):**
1. The equipment was physically too close together

**System (Root) Causes:**
1. The Risk were not properly identified before work started
2. Lack of knowledge & lack of training of Y
3. Lack of training of lifting operations by Z
4. Inadequate Supervision on site
5. Inadequate planning of the job
6. Lack of procedure for site control of positioning of equipment & lifting operations

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System Failures against your Management System

Illustrative Example Only

1. Regulatory Compliance and Conformance System (Health, Safety and Environment Protection Policy);
2. Accountability, Responsibility and Authority System (Statement of Responsibility document);
3. Employee Participation (e.g., via Occupational Health Committee, Local Safety Committee);
4. Goals and Objectives;
5. Performance Measurement System;
6. System Planning and Development Plan;
7. Hazard/Risk Identification and Assessment System;
9. Training System;
10. Hazard and Control System (e.g., Design Process, Emergency Preparedness and Response System, Hazardous Agent Management System, etc.);
11. Preventative and Corrective Action System;
12. Procurement and Contracting System;
13. Communication System;
15. Evaluation System (Audit process);
16. Incident Investigation and Root Cause Analysis System; and

System (Root) Causes

1. The Risk were not properly identified before work started
2. Lack of knowledge & training of X
3. Lack of training of lifting operations by Z
4. Inadequate Supervision on site
5. Inadequate planning of the job
6. Lack of procedure
Key lessons from Case Study – Illustrative only

- Remember very often it is the small repetitive jobs that will catch you out!

- Every job however small should undergo -------------------------

- It is essential that a “job plan” -----------------------------

- Constant supervision by site management is “key” especially -----------------------------

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