CLIENT CASE STUDY · MAJOR ENGINEERING PROGRAMME, HIGH HAZARD SITE

The procedures were not the problem. The sign on the wall was.

A first of a kind programme of work in plant infrastructure that had not been accessed since the 1960s. The leadership were concerned that the emergency arrangements to support the programme weren't adequate. The instinct was sound. The cause sat further upstream, spread across supervision, behaviours and what the workforce had come to expect and it was visible on a wall within ten minutes of us arriving.

2 hours	Zero	On time	Retained
On site before the real risk showed itself	Safety incidents, accidents or injuries across the programme	And on budget, on a first of a kind campaign in 1960s plant	Berwicks now the client's standing risk partner

About this case study. *The client and the site are not named. The observations described here were made during a Berwicks site visit and are recorded in the engagement report. The photograph was taken by Berwicks on site.*

Ten minutes into the site tour, this was on the wall.

A mandatory hearing protection sign. Sunglasses, a grin, musical notes. Somebody had drawn on it, and somebody else had decided it could stay.

On its own it is graffiti. Read properly it is a chain. An individual who had come to treat some rules as negotiable. Supervisors holding the schedule ahead of the standard, because the schedule was what they were measured on. A sign that had been there so long it had stopped registering with anyone walking past. And a leadership team who could feel something was wrong and had reached for the part of the system they could actually see – the procedures.

That is how risk behaves inside an organisation. It does not stay in the box drawn around it. It travels through the connections between functions and surfaces a long way from where it started, usually in the one place nobody is looking.

Photographed on arrival, before a single document had been opened.

Why this matters

Complex work in high hazard industries does not produce separate risks. It produces one interdependent risk with several faces. Schedule pressure, supervisory authority, competence and culture all draw on the same account. Squeeze one and the others move, quietly, somewhere else.

Clients see the face of it nearest to them. The cause usually sits two or three connections away, in a function that has no reason to think it owns the problem.

That distance is the difficulty. Nobody inside the business is wrong about their own part. They simply struggle to see the whole chain from where they stand; it is the chain that fails.

What the client could see. What we could see.

The client was about to start a sequence of work in parts of the infrastructure that had not been opened up since the 1960s. Unfamiliar hazards, no living practice, nobody still on site who had done it before. The leadership were not convinced the workforce were ready, and that instinct was sound. They traced it to the emergency procedures, because procedures were the part of the system they could see, own and change.

What the client could see The part of the system in plain view	
The programme	A first of a kind campaign in infrastructure last worked on in the 1960s, with no established practice to fall back on.
The concern	Management doubted the emergency arrangement were fit for such a uique programme of work.
The diagnosis	The emergency procedures were out of date and unfit for the hazards the campaign would create.
The logic	Better instructions produce better behaviour, so start with the instructions.
Why it stops there	Procedures are visible, ownable and easy to scope. What they depend on is none of those things, from any position inside the business.

What we could see One risk, distributed across the organisation	
The signal	A defaced mandatory PPE sign, still up. Nobody had drawn on it that morning, and nobody had taken it down since.
The chain	A workforce who had come to treat some rules as negotiable. Supervisors measured on schedule rather than standards. A sign nobody registered any more.
The dependency	Competence, supervision and schedule were drawing on the same account. The procedures sat downstream of all three.
The blind spot	Every level was reporting accurately on its own part. Nobody owned the connections between them, so the risk never appeared whole on anyone's desk.
The consequence	New procedures would have been issued into a system that had already demonstrated what it does with a rule.

A defaced sign is not a housekeeping issue. It is a measurement of everything upstream of it.

How we got to the cause

The client had a symptom, a scope and a sound instinct that something needed improving. Getting to the cause meant following the connections out of that symptom, into functions with no idea they were part of it, then putting it in front of a leadership team who had asked for something narrower. They listened. We had that conversation before writing a word of procedure and it was the engagement. Everything after it was delivery.

1. **Followed the signal, not the scope.** We treated the defaced sign as evidence rather than housekeeping, and traced what it depended on until we reached the decisions actually driving behaviour on that site.
2. **Read the organisation, not the document set.** Interviews across shifts and grades, and observation of the work as it was really done. Interdependent risk shows up in the gaps between functions, never inside any one of them.
3. **Mapped the connections.** Schedule, supervisory authority, competence and culture set out as one system, so leadership could see how a decision taken in one produced a failure in another.

4. **Told the client what they could not see.** Plainly and with the evidence. Management had scoped the work in good faith, and once they could see how the pieces connected they backed the wider fix without hesitation.
5. **Fixed the chain, then the paperwork.** Supervision, standards, competence and practise dealt with first. The procedures were rewritten with the crews as part of that work, not instead of it.

What changed, and what it delivered

The procedures were the visible part. What made the programme safe was the system underneath them.

Focus area	What it covered	Effect
Root cause	The supervisory and cultural conditions sitting behind the behaviour	**The rules meant something again**
Interdependencies	Schedule, competence, supervision and risk owned as one system rather than four	**Decisions stopped quietly undermining each other**
Competence and practise	Role based training, rehearsal and exercising ahead of each phase	**Capability proven before the work started**
Risk ownership	Hazards of sixty year old plant identified, owned and tracked live	**Surprises found on paper, not in the field**
Procedures	Rewritten with the crews, against the work as it would actually be done	**Instructions people recognised and used**

Where the value was created

- **Cause, not symptom.** The client had diagnosed a documentation problem, which was reasonable from where they sat. Accepting it was the easy commercial choice and would have left the real risk exactly where it was.
- **Risk read as a system.** Two decades in high hazard industries teaches you how risk permeates an organisation, moving between functions and settling where nobody owns it. Recognising that pattern early is what we are actually hired for.
- **Sight the client cannot have.** Nobody inside a business can see their own normal, however capable they are. What had become unremarkable on that site was the first thing noticed by people who have walked plants like it for years.
- **The standing to say it.** Telling a leadership team the problem sits with the organisation rather than its paperwork only works coming from people who have stood on plants like theirs. Experience is what makes it land rather than offend.
- **A partner, not a report.** The relationship continued past the programme because the value was in the judgement, not the document.

What the client would have got either way

Measure	The scope as written	What Berwicks delivered
Diagnosis	A documentation gap	**A chain of conditions, evidenced on site**
Unit of analysis	The procedures	**The organisation and its dependencies**

Measure	The scope as written	What Berwicks delivered
Evidence	The document set	**Observation, interviews across grades and what the plant showed us**
Where risk was assumed to sit	In the plan	**Between functions, owned by nobody**
Supervision and culture	Not in the original scope	**Addressed as the cause**
Measure of success	Documents issued	**Programme delivered without incident**
Risk after handover	Recorded	**Owned, tracked and independently assured**

The value added

Everything below is measurable, and every measure belongs to the client rather than to us. None of it needed a bigger budget. It needed the work pointed at the cause early enough to matter.

The sign came down early on. That was never the point. What put it there was.

Measure	Outcome	How it is evidenced
Schedule	**Every phase delivered to plan and the campaign completed on time**	Programme baseline against actual completion
Cost	**Delivered within the approved budget, with no unplanned spend on rework or stoppage**	Client cost report at programme close
Safety performance	**No incidents, no accidents and no injuries across the full campaign**	Client incident reporting for the period
Lost production	**No stoppage from safety intervention. On a campaign of this size a single lost day runs well into six figures**	Client's own production values
Rework	**Procedures written once, with the crews, and used as written. No reissue during delivery**	Document revision history
Regulatory position	**No enforcement action and no improvement notice arising from the campaign**	Regulator interaction record
Capability retained	**Trained, rehearsed and exercised role holders still in post at close, ready for the next phase**	Training and exercise records

The risk is rarely where the scope says it is.

Berwicks works alongside leaders in complex, high hazard industries where risk is interconnected and hardest to see from the inside. We find the cause behind the presenting symptom, show how it connects, and stay involved long enough for the change to hold. To discuss how this would apply to your operations, get in touch – info@berwicksconsultants.com