



# HSE NEWS

## WORKING FOR YOU TO KEEP YOU SAFE

### Latest HSE Statistics YTD 31 Dec

|                                          | 2014 | 2015 |
|------------------------------------------|------|------|
| Workplace fatalities                     | 4    | 2    |
| Non-work related fatalities              | 4    | 4    |
| Non-accidental deaths (NADs)             | 13   | 13   |
| Lost Time Injuries (LTIs)                | 55   | 49   |
| All injuries (excluding first aid cases) | 171  | 167  |
| Motor Vehicle Incidents (MVIs)           | 96   | 75   |
| Roll over - MVIs                         | 28   | 25   |
| Serious MVIs                             | 31   | 31   |
| Lost Time Injury Frequency (LTIF)        | 0    | 28   |

### Life Saving Rules Violations

#### YTD 31 Dec 2015

|                          |   |
|--------------------------|---|
| Journey management       | 0 |
| Speeding/GSM             | 0 |
| Seatbelts                | 0 |
| Overriding safety device | 0 |
| Working at heights       | 0 |
| Permit                   | 0 |
| Confined space           | 0 |
| Lock out tag out         | 0 |
| Drugs and alcohol        | 0 |
| Gas testing              | 0 |
| Smoking                  | 0 |
| Suspended Load           | 0 |

### Vehicle Class A/B Defect

#### YTD 13 December 2015

|         |      |
|---------|------|
| Class A | 105  |
| Class B | 3263 |

### HSE TIP

Near Miss incidents are gifts that enable us to learn and rectify the situation before it escalates to injuries or damages.

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## Important News



PDO aims to maintain a safe and healthy working environment by correcting situations that caused or could likely cause injury or damage. When an incident occurs, it is important to report the occurrence so corrective actions could be taken to make sure that a similar or more serious incidents do not re-occur. An incident is defined as "an unplanned and undesired event or chain of events that have, or could have, resulted in injury or illness, damage to assets, environment, company reputation, and/or consequential business loss". There are different types of reportable incidents:

### What You Need to Know

#### What you need to know?:

A Near Miss incident is an unplanned event that did not result in an injury, illness, or damage to assets, environment or Company reputation, but had the potential to do so if some circumstance of the event were different. Only a fortunate break in the chain of events prevented an injury, fatality or damage.

#### Why report a Near Miss?:

- Uncovers valuable information that otherwise might not be identified.
- Enables Company to pro-actively control/eliminate hazards before a tragic or costly incident occurs.
- Develops a positive safety culture and increases safety ownership and reinforces workers' self-esteem.

#### Your Support Is Needed !:

Since the introduction of the new Near Miss reporting tool on December 10<sup>th</sup> 2015, less than 70 incidents have been reported! You could help by entering many of the Near Miss incidents that you witness on a day to day basis. This has enabled MSE team to follow up to address potential harm to people, asset and environment.



- Unsafe acts/conditions including Life Saving Rule violations.
- Near Misses
- Incidents with consequences (People injury, Asset Damage or Damage to Environment)

Normally, staff are good in reporting incidents with consequences. However, reporting Near Miss incidents is as important as reporting incident s with consequences. Near Miss incidents are gifts that enable us to learn and rectify the situation before it escalates to injuries or damages.



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### HSE Advice Note

There are many examples of what could be considered as a Near Miss such as:

- Someone trips on uneven pavement while walking. Being agile and empty handed, that person regains balance with no harm done.
- You stumble because of an uncovered hole outside of a building but you don't fall.
- A projectile hits your safety glasses but does not injure your eye.
- An object falls near you and did not hit you.

There are other examples related to process safety Near Miss incidents such as:

- Mechanical seal leaks
- Momentarily the AP, LP and HP control valve failed due to mechanical "valve failure" or instrument component failure.

- Failure of the Blanketing gas That is why a new [Near Miss Reporting](#) template was control valve in fix roof tanks, developed and introduced to the organization. The resulting in blow hatch valve template is web-based and can be accessed by all staff including contracting community. Reporting staff
- Hi-Hi level at tanks failed and can be anonymous as only essential details are resulted liquid carry over to needed to act on the incident. flare knock out vessel and trip station.
- Hi-Hi level at Bulk/Test All are encouraged and requested to report including Separators failed and resulted visitors to PDO. If you don't have access to the web, liquid carry over to flare knock then please ask a colleague or a supervisor to report out vessel and trip station. on your behalf.

#### Who reports a Near Miss?

#### How to report a Near Miss?

There might be elements to prevent people from reporting Near Miss incidents such as difficulty to report the incident, bureaucracy in terms of paperwork, loss of reputation by reporting many incidents. It has to be clear that PDO interest to receive Near Miss reports is to create a safer and healthier working environment.

PDO staff have the option to either enter the incident directly to PIM or go to <https://web.pdo.co.om/hsetool/nearmiss/nearmiss.aspx>; this link is accessible by everyone including contractors with internet access.



### HSE Apps

PDO CORPORATE HSE

### NEAR MISS - INCIDENT (WITHOUT CONSEQUENCES)

Location : ☒ Bahja ☐ Fahud ☐ Harweel ☐ Lekhwair ☐ Marmul ☐ Mina Al Fahal ☐ Nimr ☐ Qarn Alam ☐ Yibal

\*Responsible Department : --- Select ---

\*Incident Sub Type : --- Select ---

Company Name :

Contract Number :

Email ID (Optional) :

#### Where did the Incident Occur ?

\*Specific Location :

#### When did the Incident Occur ?

\*Date Occured :

Date Reported : 22/11/2015

#### Description

\*Event Description :

Enter Corrective Action Taken :

All the fields marked as (\*) are mandatory



