



# HSE NEWS

## WORKING FOR YOU TO KEEP YOU SAFE

### Latest HSE Statistics YTD 15 January 2016

|  | 2014 | 2015 |
|--|------|------|
| Workplace fatalities                     | 0    | 0    |
| Non-work related fatalities              | 0    | 0    |
| Non-accidental deaths (NADs)             | 1    | 1    |
| Lost Time Injuries (LTIs)                | 1    | 1    |
| All injuries (excluding first aid cases) | 7    | 6    |
| Motor Vehicle Incidents (MVIs)           | 4    | 2    |
| Roll over - MVIs                         | 1    | 1    |
| Serious MVIs                             | 1    | 1    |
| Lost Time Injury Frequency (LTIF)        | 0.13 | 0.13 |

### Life Saving Rules Violations

#### YTD 3

|                          |   |
|--------------------------|---|
| Journey management       | 1 |
| Speeding/GSM             | 0 |
| Seatbelts                | 1 |
| Overriding safety device | 0 |
| Working at heights       | 0 |
| Permit                   | 1 |
| 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

|         |     |
|---------|-----|
| Class A | 0   |
| Class B | 119 |

### HSE TIP

Make sure the MSE3 team are in your investigation "Kick off meeting" for guidance, ensuring you are hea

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## Important News



### New HSE investigation process

By popular request, PDO simplified its HSE incident investigation process, improving its efficiency and quality whilst minimising management time, resources and meetings and ensuring only the right people are involved. It is now designed in the mindset of: "Do less but do it better". Since its launch in September the time for investigations to reach the Managing Directors table has more than halved showing the value created.



Many took the opportunity to attend a half day workshop in MAF on the 27th January to improve their knowledge of the new process and how to maximise its benefits. These include Corporate quality assurance from start to finish, guidance and support; key specialists for certain incident types, kick off meeting, ToR, less meetings, improved depth and breadth of investigations, less IRCs and action items which are better targeted for value generation.

## What You Need to Know

### Pareto Principle:

To maximise value and minimise waste, you should now adopt the Pareto principle in HSE investigation. Apply 20% effort to extract 80% of the findings. Investigate a centimetre wide but a kilometre deep as its the deep learnings that provide the maximum benefit.

### Using the right template:

It is important to use the right template so always check the PDO contractor or Corporate HSE web. The latest new version is version for LTIs is V7.0, and for AIPS its V5.0. Investigations will be rejected if any other version is used, so stay efficient and check.

### Getting it wrong:

Where contractors provide investigations which are wholly substandard and no one has attended the PDO ICAM investigation course to understand the methodology, then consequence management will be applied to pay for the waste of time and effort in PDO.



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## HSE Advice Note

### Explaining the process

If you start a journey aiming in the wrong direction, it doesn't matter how fast you travel, you will never reach your destination. That's why the new kick off meeting is so important. This short meeting formalises the team, the timeline, the rules and the critical factors to focus on. This ensures structure to the investigation so you only investigate causes relevant to the incident and not peripheral issues. It also focuses the team to deliver to a tight deadline and to think of quality instead of quantity of information and findings.

The phrase, 'a centimetre wide and kilometre deep' is key to a good investigation. By narrowing the breadth of the investigation you can focus on the depth; keep asking why each cause happened and then what led to that cause also happening, until you find the management or cultural causes of the incident. We call them the immediate, underlying and latent reasons. Only by solving the latent reasons and then spreading the learning to everyone else can we ever hope to reduce our incidents and injuries in the PDO operation, particularly our contractor and sub contractor community.

The final learning value change is in ensuring quality at each stage of the investigation. This is why the MSE3, MSE4 and MCOH team provide support and advice to all serious incident investigations relevant to their subject and the incident Owner can call upon designated experts in technical fields to join their investigation teams. By assuring the quality, direction and depth of the investigation in small meetings throughout the investigation it saves much time and effort correcting mistakes late on in the process. Never lose sight of the fact that we investigate to learn, we learn to avoid future incidents and losses.

