



## How to develop and implement an **Effective Proactive HSE Culture**

Over the past few years, it has become apparent that there is a need to produce a step by step guide to achieving an Effective Proactive HSE Culture. The common Reactive HSE Culture is slowly being improved to an Intermediate HSE Culture, but still relies heavily on personal commitment and self-responsibility for HSE. While this raises HSE to acceptable levels, it still does not go far enough towards achieving an Effective Proactive HSE Culture.

**This guide was prepared by Jose Cardita, OXD/2, of Oil Products Distribution in collaboration with Simon Shimmin, OXXM, Oil Products HSE MS Implementation.**

This document was issued in November 1999 by Shell International Petroleum Co, London, OXX.

© Shell International Petroleum Company (SIPC). Permission to reproduce any part of this publication should be sought from SIPC.

Agreement will normally be given, provided that the source is acknowledged, except for parts shown to be from other sources.

Shell companies have their own separate identities, but in this publication the collective expression 'Shell' and 'Group' are sometimes used for convenience in contexts where the reference is to companies of the Royal Dutch / Shell Group, or where no useful purpose is served by identifying the particular shell company or companies.

*Over the past few years, it has become apparent that there is a need to produce a step by step guide to achieving an Effective Proactive HSE Culture. The common Reactive HSE Culture is slowly being improved to an Intermediate HSE Culture, but still relies heavily on personal commitment and self-responsibility for HSE. While this raises HSE to acceptable levels, it still does not go far enough towards achieving an Effective Proactive HSE Culture.*

The following guide explains the common Reactive HSE Culture, prevalent throughout the world, and offers practical strategies, tactics and actions that can be used to move through an Intermediate HSE Culture towards an Effective Proactive HSE Culture. These strategies, tactics and actions will be different for each Operating Unit depending on its HSE culture and the national HSE culture. The Effective Proactive Culture focuses on team HSE performance and shared responsibility from the company and contractors alike, and aims to bring about a shift in culture internally, rather than rely on annual results to prompt changes.

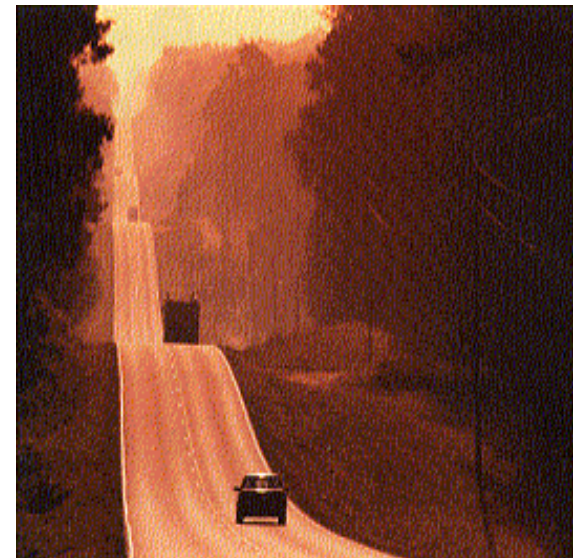
At the heart of this culture is the proactive involvement of all levels of staff and management. This guide has been produced mainly to combat the rise in Road Transport fatalities around the world, but can be applied across any other relevant area of Health, Safety, Security and Environment.

Where possible, 'real life' examples and existing communications have been used.

A Route Map shows the key steps needed to achieve an Effective Proactive HSE Culture.

All technical terms used in this guide, indicated using italics, are defined in the Glossary at the back. There is also a full list of abbreviations.

The guide ends with information on the 'Self-Sustaining HSE Stage', possible extension and integration of the approach to other business areas and a final comment.



## Route Map

1. Identifying your present HSE Culture  
What are you now?
  2. Developing a Vision  
Setting goals to achieve the Vision
  3. Strategic Blocks
  4. Proactive Actions, Indicators and Targets
  5. Weighting the Scorecard and establishing the Corporate Link
  6. Information and Communication Systems
  7. Effectiveness
- Conclusions
    - The Self-Sustaining HSE Stage
    - Extending and integrating this approach in other business areas
    - Final comment
  - HSE Tips
  - Abbreviations, Glossary, References

*Before you can begin to move towards an improved HSE performance, it is necessary to understand the nature of the various HSE Cultures. For the purposes of this document we have identified three types of HSE Culture:*

- The Reactive HSE Culture
- The Intermediate HSE Culture
- The Effective Proactive HSE Culture

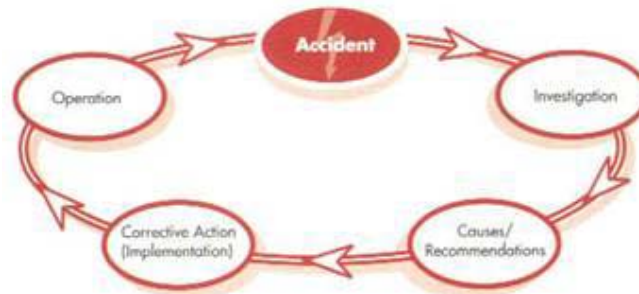
### The Reactive HSE Culture

**Focus: 'Management and supervisory control'.**

In this culture the emphasis is on management and supervisory control to enforce HSE rules, regulations and procedures and it relies heavily on the use of fear and discipline.

This is still a common approach world wide despite evidence that with this model it is not possible to achieve continuous HSE performance improvement. HSE performance is characterized by cycles, closely related to top management attention and it's common to see a decrease in HS performance if the company has been recently streamlined.

Accident (the vicious circle) 1.1



The Reactive HSE Culture is concerned with 'what went wrong?' In other words, any improvement in HSE performance is only due to learning from incidents after they occurred.

The monitoring process provides information only after health, safety, security and environmental incidents. These incidents can be subdivided into *accidents* and *near-misses*. Usually, the reporting of *near-misses* is extremely poor because their potential significance is not realized, the reporting systems are too complex or because those involved do not report the *near-miss* for fear of being 'blamed'.

In this culture the common starting point of the HSE process is an accident (1.1) and the analysis is mainly related to active failures (breached

defences and unsafe acts). Only when Tripod methodology (1.2) is applied are the latent failures existent deeper in the operation, facility, or business activity demonstrated.

It is a culture where the mind set of staff and management is in a 'Reactive' mode, so the company is always 'expecting to be lucky'.

It is a culture where performance is only measured through reactive indicators such as LTIF (Lost Time Injury Frequency), TRCF (Total Reportable Case Frequency), TROIF (Total Reportable Occupational Illness Frequency), waste generated and control limits exceeded. Where incentive schemes do exist they are exclusively related to reactive indicators. It is an approach which has a limited capacity for HSE performance improvement and which is entirely dependent on the level of management commitment.

And because it's impossible for management to be everywhere and continuously monitor all operations, HSE performance will never continuously improve.

## The Intermediate HSE Culture

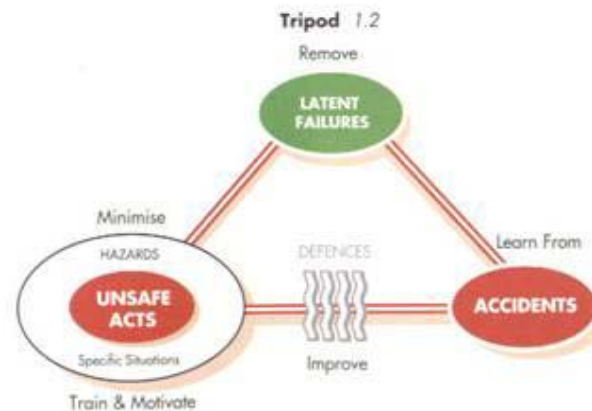
**Focus: 'Personal commitment and self responsibility for HSE'.**

In this culture the focus is on personal commitment and self-responsibility for HSE. HSE is a line management responsibility and the company is very much oriented towards results, not through programmes as before, but increasingly through management systems.

It is a culture where performance is still mainly measured through reactive indicators such as TRCF (Total Reportable Case Frequency), LTIF (Lost Time Injury Frequency), TROIF (Total Reportable Occupational Illness Frequency), waste generated and control limits exceeded. When incentive schemes exist they are still exclusively related to reactive indicators.

The 'blame' approach still exists but when an accident happens the Tripod methodology is commonly applied identifying the *latent failures* existent deeper in the organization.

This culture requires an HSE Management System and, whenever applicable, an HSE Case to reduce risks to ALARP (As Low As Reasonably Practicable) levels, promoting and raising the capacity for improvement in HSE performance. An Intermediate HSE Culture is one where:



- *Risk management* begins to play an important part in the HSE Management System.
- Managers are concerned with 'what could go wrong?' and HSE performance improvement is a result of identifying areas for improvement and implementing necessary remedial actions. This approach leads to the identification of possible risks and implements ways to control or lessen their effect to ensure an overall improvement in HSE performance.
- Individuals start to share thoughts and ideas, but team HSE performance and shared responsibility have not yet been developed.
- Processes are beginning to be understood, although most improvements are based on

procedures and individuals are mainly self-managed.

- Significant HSE performance improvements can be achieved but eventually a plateau is reached, after which, further improvements, whatever the effort, cannot be achieved.

## The Effective Proactive HSE Culture

**Focus: 'Team HSE performance and shared responsibility'.**

In this culture the focus is on team HSE performance and shared responsibility. The proactive involvement of all levels of the organization including contractors, is vital to overall success and is crucial to achieving excellence. This culture implies a link between the top and the bottom of the organization not only within the company but also within key contractors.

A continuous process of field information reporting, with a proactive 'no-blame' approach, becomes a key focus for the sharpened workforce and requires the proactive involvement of first line supervisors. This should lead to the development of trust and confidence in management. Finally,

safer behaviour, personal motivation, ownership and empowerment are achieved.

The Effective Proactive HSE Culture can be defined as:

‘The product of peoples’ values and beliefs, their behaviour, their commitment and their proactive involvement, translated into a demonstration of continuous HSE performance improvement.’

It is culture that asks questions such as:

- What could go wrong?
- What are our Unsafe Behaviours?
- Which are the key Unsafe Behaviours?
- What are the related Safe Behaviours?

HSE performance is a consequence of learning from the continuous identification of areas for improvement related to the latent stages leading to incidents. These stages also include the sharp-end workforce’s own HSE habits that may lead to incidents.

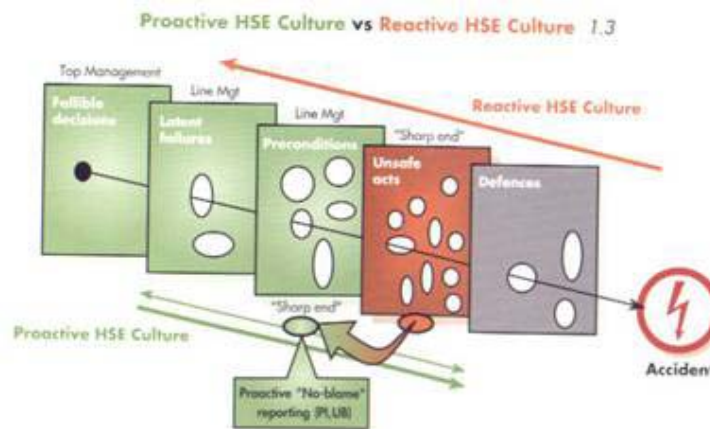
At the heart of this culture is an HSE Management System designed to improve the company’s long-term HSE performance. A proactive HSE culture is one where:

- People live in a ‘what if?’ mode each day and where the rule of thumb is ‘check out the risks before you make a move’.
- The identification of unsafe behaviours, hazardous scenarios and related latent failures plays a key role (1.3).
- A company takes into account what is manageable and what is not and so sets the right internal (proactive) HSE goals.

The continuous and increasing participation of sharp-end workforce is a sign that the process is moving ahead in the right direction.

This culture leads to the identification of structural and organizational weaknesses, whilst ensuring simultaneously the identification of fallible decisions thus improving top management performance. It also identifies safe behaviours, controls for threats and migration / recovery measures for consequences, leading to

continuous improvement of the overall risk conditions. This increases business efficiency while motivating and ensuring the proactive involvement of the workforce.



- Company and contractor HSE risks are continuously minimized while continuing day to day business.

It is a 'learning culture' that moves forward using the effective experience of all levels in the organization by identifying hazardous scenarios. It does not confine the identification of hazardous scenarios to those with line responsibility for an activity. Instead it encourages everyone, all levels of line staff, former members of a work group who may have valuable experience that is otherwise lost to the organization and others who may have valuable ideas, even if they have never worked in the field in question, to contribute to the overall improvement of HSE performance in the company.

It is also a culture where:

- Team performance and shared responsibility are a must. An effective Proactive HSE Culture establishes processes that recognize, evaluate, monitor and improve individual, peer and team HSE performance across the whole workforce.
- Monitoring provides information even in the absence of any incident related to health, safety, security or environment.
- Proactive performance indicators play the main role in incentive schemes. These indicators are forward looking, raising awareness of incidents that could happen,

as for example risk based performance indicators.

- An open approach to communication is established as well as a blame-free, proactive reporting basis. This approach requires an effective HSE Management System (1.4) and whenever applicable, a related living HSE Case to reduce risks to ALARP (As Low As Reasonably Practicable) levels, promoting and raising the capacity for continuous improvement in HSE performance.

The first indications that a Proactive HSE Culture is penetrating the organization is an improvement in the Proactive HSE Performance Indicators. In the medium term, and as a consequence, the Reactive HSE Key Performance Indicators (KPIs) will also start to improve.





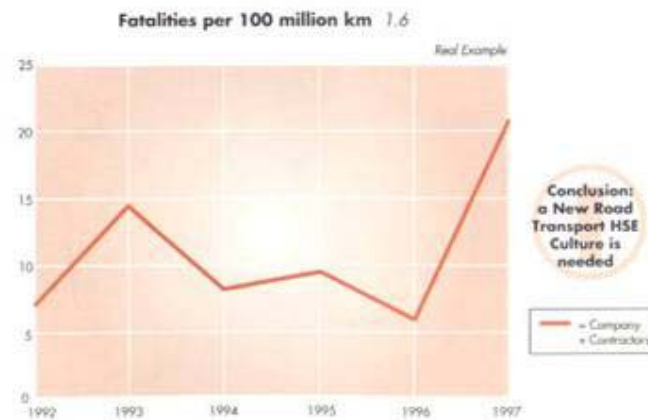
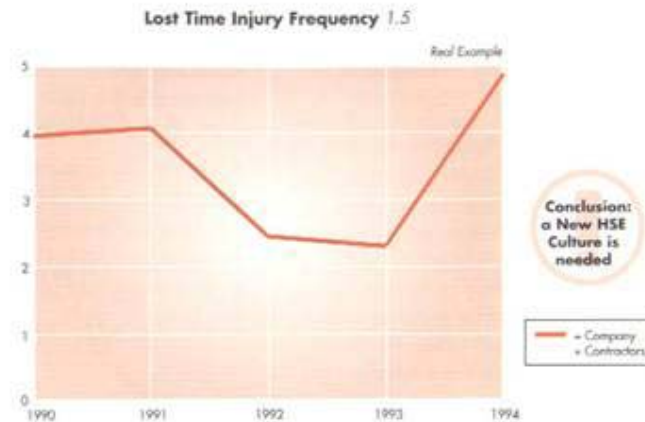
## Where are you now?

Now that you have familiarized yourself with the three HSE cultures, you need to evaluate your past HSE performance.

### Past HSE Performance

It's recommended that you analyze the past HSE performance from at least the last 5 years to build up an accurate picture of performance evolution. For example, figures 1.5/6 clearly show that HSE performance does not improve in a reactive HSE environment and can only be continuously improved if an enhanced HSE culture, followed by an Effective Proactive HSE Culture is developed and established.

Taking into account your past HSE performance with the HSE culture definitions allows you to identify your present HSE culture.



## 2

## The Vision – Setting goals to achieve results

Having a Vision of where you want to be is crucial to achieving medium and long-term HSE objectives. The Vision can be defined as the overall long-term objective and can only be achieved by implementing an effective HSE Management System. The Vision can typically

*Real Example 2.1*



take between 3-5 years to reach (2.1), but in some cases, urgent short-term measures may be necessary to reach minimum HSE levels before the long-term objectives can begin to be implemented.

You will need to set several goals to reach your Vision. Specific Visions for contractors can also be set to run alongside those for the company, for example, by adopting a 'Partnership Philosophy'

(2.2). This can be especially successful in harsh HSE environments.

*Real Example Road Transport Contractors 2.2*

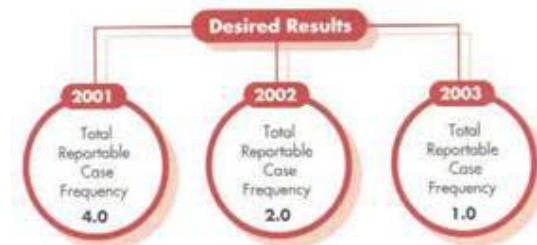


To be successful, the Vision needs to be relevant, realistic and should lead to the commitment and proactive involvement of everyone.

### Future Goals

To achieve the Vision, intermediate goals need to be set on a year to year basis to improve the present HSE performance to the Vision level. This 'stepped' approach can be translated into a series of annual Reactive HSE Performance Indicators and targets (2.3/4) and should be achievable within 3-5 years. This series will include the next annual target.

Example Road Transport - Targets 2.3



Example Road Transport - Targets 2.4



3

### Developing an effective proactive approach

*Oil Products is moving from a 'trust me' to 'tell me' to a 'show me' philosophy (3.1). The evidence for this can be seen in HSE Cases, with a continuous reduction of risks to ALARP levels and also in HSE performance results published in external reports.*

Reactive HSE Indicators (with related targets) are usually required to meet external requirements and are represented in the 'Desired Targets' area of Scorecards (see 4.1/2 overleaf). In order to demonstrate continuous HSE performance improvement these targets must be clearly defined.

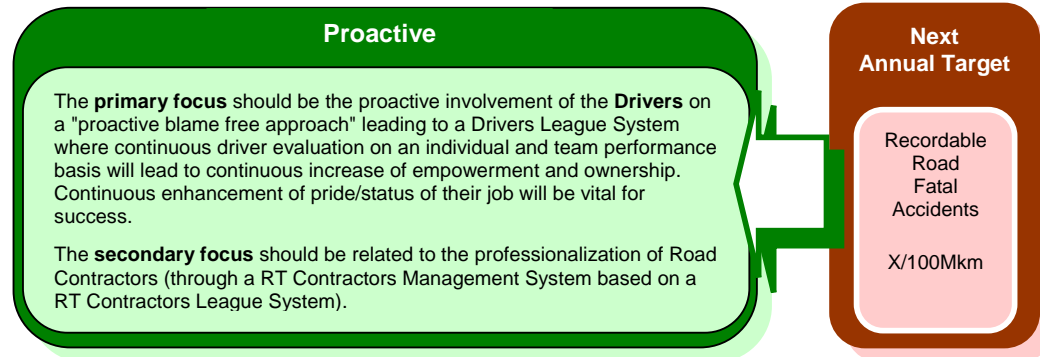
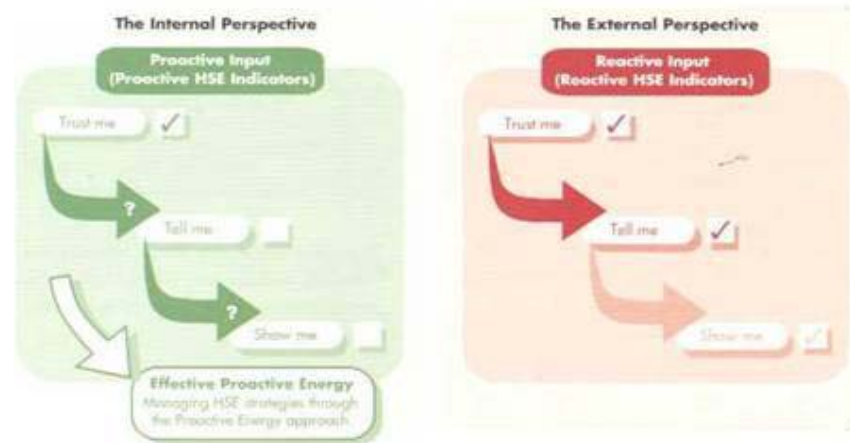
The strategies, tactics and actions which follow are related to targeting HSE performance improvement. The attached examples shows how this can be applied to the next annual target (3.2).

Usually one or two Reactive HSE Indicators are chosen. However, these Reactive HSE Indicators only provide a visual picture of desired progress for use in external performance reports.

Developing the necessary related strategies, tactics, logistics and internal targets is still required.

The Reactive HSE Indicators are usually Key Performance indicators (KPIs) and allow comparison with other Operating Units and companies.

Adding the Internal Perspective 3.1



## 4 Strategic Blocks

*Strategic Blocks (4.1/2) are strategies with related targets that allow a department or even an Operating Unit to reach its desired HSE performance improvement.*

The first group of Strategic Blocks should ensure the proactive involvement of all levels of the company and contractors and focus on the main actions needed to achieve specific targets. This will also help to create a 'knock-on' effect and help establish the proactive and 'living' systems needed to ensure continued HSE performance improvement.

Each Strategies Block in the first group in each example has a specific purpose. For example:

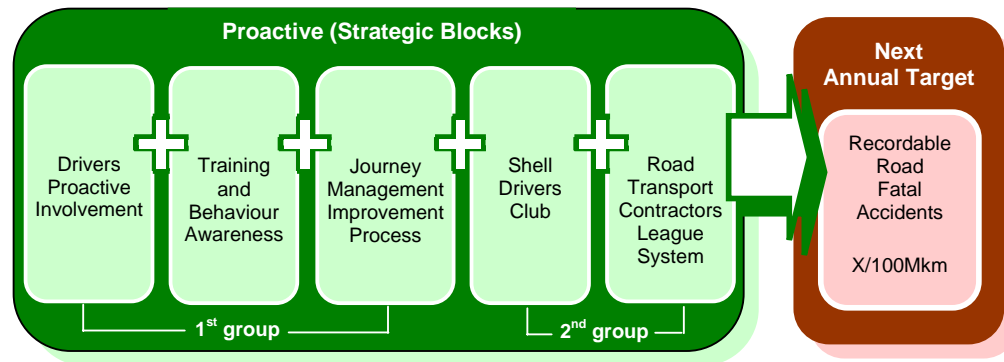
- Drivers proactive involvement
- Sharp-end workforce and supervisors proactive involvement
- Training and behaviour awareness
- Journey management improvement
- Contractor audits and management facility visits

The Strategic Blocks in the second group in the examples are related to systems. For example:

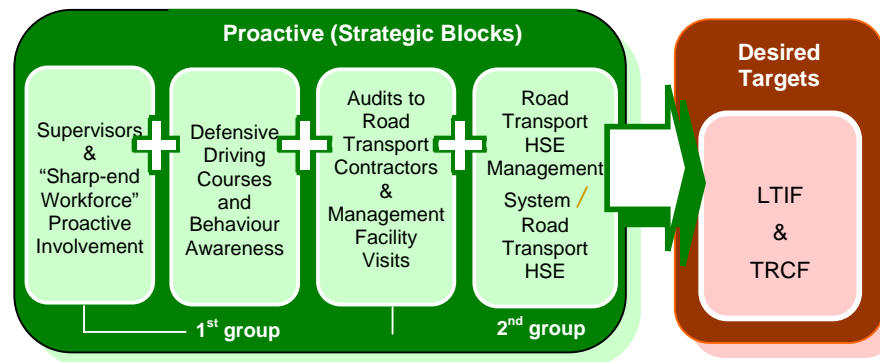
- Drivers Management System

- Contractors Management System
- HSE Management System
- HSE Case

Real Example Road Transport Scorecard 4.1



Real Example Road Transport Scorecard 4.2



## 5 Proactive Actions, Indicators and Targets

*Each Strategic Block can be translated into a series of Proactive Actions and HSE indicators and identifies a specific strategy leading to the effectiveness of an overall HSE Management System (5.1).*

Each action or HSE Indicator should have a specific annual target. Examples include:

- Potential Incidents
- Unsafe Behaviours / Safe Behaviours
- Unsafe Conditions
- Defensive Driving Courses
- Special training
- HSE Tips
- HSE Posters
- Tool Box Meetings
- Overall training efficiency
- Tachographs
- On-board computers
- Drivers rest stations

- Audits of contractors
- Management Facility Visits
- Management Field Visits

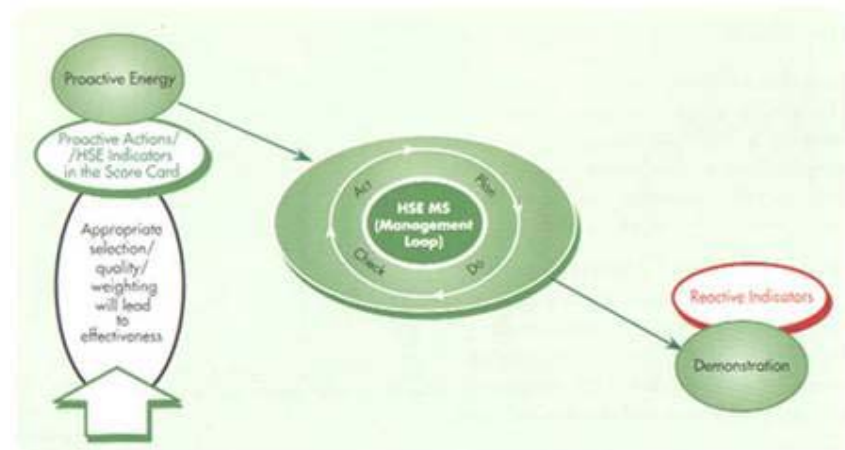
Once these actions are in place they will lead to proactive and 'living' systems such as:

- Drivers Management System
  - Drivers League System
  - Team (e.g. Drivers) Behavioural Performance System
- Contractors (e.g. Road Transport Contractors) Management System
  - Road Transport Contractors League System
- HSE management System
- HSE Case

### The 'no blame' approach

Being able to identify what can happen before it happens is crucial to the prevention of future

The adequate selection of Proactive Actions / HSE Indicators plays a relevant role in an Effective Proactive HSE Culture 5.1



incidents. In order to encourage staff to report what can happen, it's essential to adopt a 'no blame' proactive approach. This approach is also especially relevant with near misses.

Installing a 'no blame' system of proactive reporting actively encourages the proactive involvement of all levels – in particular the sharp-end workforce. This approach can also be applied to other relevant HSE areas such as Unsafe Behaviours and Unsafe Conditions.

## The Potential Incident Concept

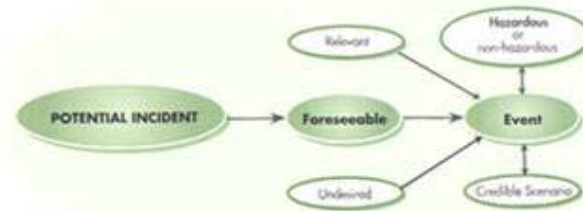
The Potential Incident concept (5.2/3/4) is a very important tool in an Effective Proactive HSE Culture. Avoiding injury and loss of life to staff and preventing other incidents from occurring helps increase productivity, business efficiency and morale.

A *Potential Incident* is defined as:

‘A relevant, foreseeable, credible and undesired hazardous event with a foreseeable and quantifiable consequence, from which HSE lessons can be learned by interested parties.’

Any *Potential Incident* is usually related to one or more Unsafe Behaviours and important lessons can be learned from the *Potential Incident* Concept. The concept can also be applied to undesired non-hazardous events (5.5).

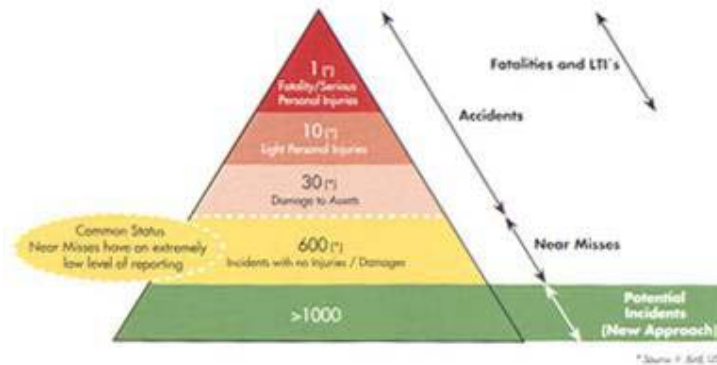
Potential Incident 5.2



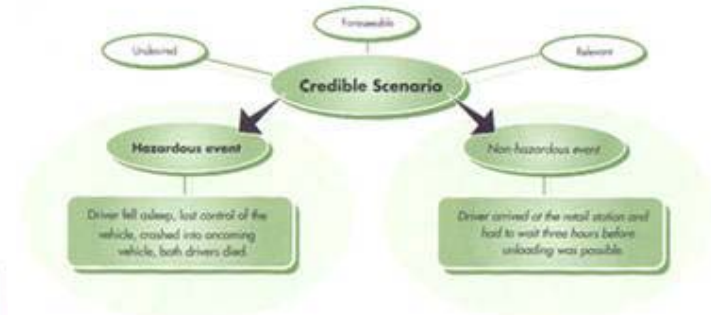
Potential Incidents Reporting: New Approach vs Incidents Reporting Traditional Approach 5.4

Aspects	Potential Incidents	(Incidents) Near Misses	(Incidents) Accidents
Observed Incidents outside Company Operations	Reportable	Not Reportable	Not Reportable
Human Blame Factor	Non-Existent	Existent	Existent
Occurrence of Actual Incidents	Not Necessary	Necessary	Necessary
Imagination / Assertive Creativity	Yes	No	No
Performance Reward	Effective	Difficult	Difficult

Incidents Pyramid (The New Layer - Potential Incidents) 5.3



Application of Potential Incident Concept to Hazardous and Non-Hazardous Events 5.5



Reporting *Potential Incidents* (5.6) without fear of blame plays an important part in raising HSE awareness – particularly among the sharp-end workforce. However, it's the quality of reporting that's important not the quantity. The Risk Assessment Matrix should be used to assess the importance of reported *Potential Incidents*. It can be helpful to establish a 'High Added Value PI Frontier' in the Risk Assessment Matrix that can be moved from year to year. This helps the proactive involvement at all levels to focus on the targeted risk areas (5.7).

The continual reporting of *Potential Incidents* is a simple and effective way to keep the Hazards and Effects Management Process (HEMP) alive. As a result, both the HSE Management Systems and the HSE Case are kept alive. For more information, refer to the Oil Products Guide – How to Develop an HSE Case in Marketing Operations. There are typically two sources of *Potential Incidents*:

1. **Memory.** This is where staff report incidents (near misses and accidents) that occurred in the past but were never previously reported.
2. **Foresight.** This is where staff who fully understand the *Potential Incident* concept begin to foresee relevant and useful incident scenarios before they occur.

Potential Incident

Reporting Form

SHELL _____	Contractor _____
Name/Reference Indicator _____	Name _____
Department _____	Company _____

Description: \_\_\_\_\_

Author (PI) \_\_\_\_\_  
Signature / Date \_\_\_\_\_

Potential Incident (PI)		Assessment				
Threat	Consequence	People (P)	Assets (A)	Environment (E)	Reputation (R)	Risk

Controls (Threats)

Recovery Measures (Consequences)

Head of Department (PI related) Signature / Date _____	HSE Focal Point (PI related) Signature / Date _____
-----------------------------------------------------------	--------------------------------------------------------

Areas for Improvement

AFI (Number)	Areas for Improvement (AFI)	Sub-Group	Energy Group	Initial Risk Level (PI)		
				Low	Medium	High

AFI (Number)	Remedial Action (AFI)	Accountable Party	Due Date		Residual Risk Level		
			Forecast	Actual	Low	Medium	High

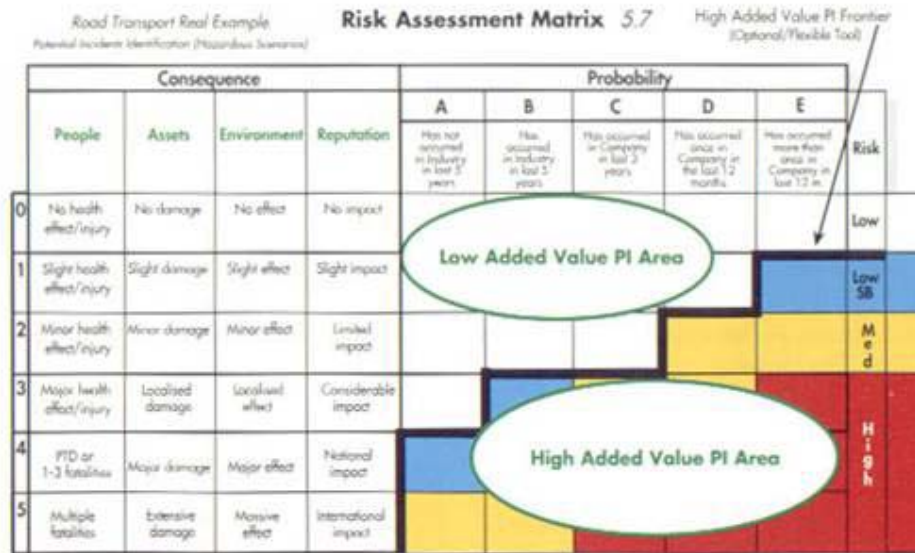
Head of Department (AFI related) Signature / Date _____	HSE Focal Point (AFI related) Signature / Date _____
------------------------------------------------------------	---------------------------------------------------------

The *Potential Incident* Concept is a particularly relevant tool in an Effective Proactive HSE culture because it aims to eliminate *accidents* and therefore improves operational and business efficiency (5.8).

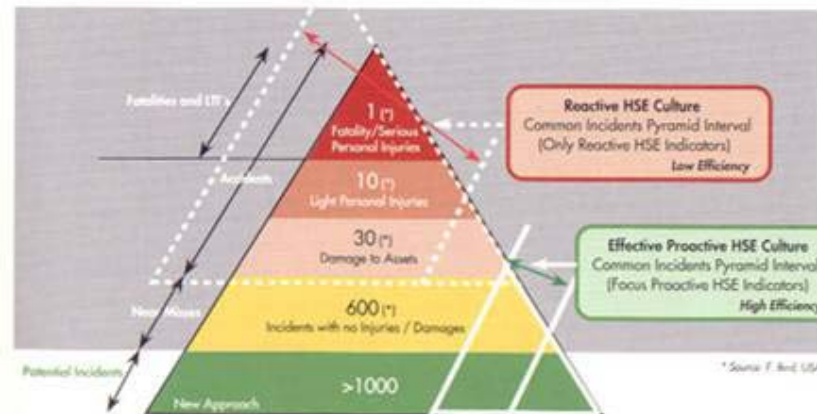
### Unsafe and Safe Behaviours

Under the 'no-blame' approach, an Unsafe Behaviour is relevant, foreseeable, credible and undesired behaviour that can lead to a foreseeable consequence, from which important HSE lessons can be learned by interested parties. A *Potential Incident* may have one or more related Unsafe Behaviours.

Reporting of Unsafe Behaviours (5.9) also plays a relevant role in raising HSE awareness. By identifying the main Unsafe Behaviours it's possible to identify the related Safe Behaviours. Once this has been done, collaboration between management, first line supervisors and the sharp-end workforce is recommended to identify and achieve the behavioural change. Measuring Safe and Unsafe Behavioural performance on a team on a team basis is an important tool to increase team performance and shared responsibility. The role of first line supervisors in this area cannot be underestimated.



Common Incidents Pyramid Intervals 5.8





This collaboration encourages active involvement and increased empowerment of the sharp-end workforce. Eventually, a better understanding of Safe and Unsafe Behaviours will lead to a change in attitude and therefore a change in the HSE climate.

**Unsafe Conditions**

Reporting of Unsafe Conditions under the ‘no-blame’ approach also plays an important role. For instance, drivers should be encouraged to report hazardous areas and ‘black spots’ on driving routes. By reporting these ‘hazardous spots’, appropriate route maps can be given to drivers that clearly highlight the danger areas on a particular route and so help them to avoid incidents.

**Other Actions and HSE Indicators**

There are other ways to raise HSE awareness among the sharp-end workforce. On the following pages you will find some proven methods already used by Shell around the world.

**HSE Tips**

Depending on the HSE climate, HSE tips should be made relevant and specific to the locality or country. For example, what is relevant in Pakistan is not necessary relevant in Uganda. Examples

can be found on pages 32 – 44. Some areas covered include:

- Potential Incident (5.10 – 5.14)
- Safe / Unsafe Behaviours (5.15/16)
- Special advice (5.17 – 5.24)
- Route mapping (5.25)
- Special local / country holidays / festival (5.26/27)
- Special team results information (5.28 – 5.30)
- External Accidents (5.31)
- Company / Contractor Incidents (*Near Misses or Accidents*) (5.32/33)
- Several local events (5.34).

It is generally better to distribute HSE Tips as and when considered appropriate, (rather than at regular intervals), to all members of the sharp-end workforce. HSE Tips printed on A4 sheets should also be used to keep staff up to date on relevant training courses (e.g. Defensive Driving Courses).

Behaviour

Reporting Form

SHELL	Contractor
Name/Reference Indicator	Name
Department	Company

Unsafe Behaviour

Author (UB) \_\_\_\_\_ Risk Level (HML) \_\_\_\_\_  
Signature / Date \_\_\_\_\_

Safe Behaviour

How to achieve this Behavioural change?

Author (UB) \_\_\_\_\_ HSE Focal Point \_\_\_\_\_ Head of Department \_\_\_\_\_  
Signature / Date \_\_\_\_\_ Signature / Date \_\_\_\_\_ Signature / Date \_\_\_\_\_

### Notes

The HSE Tips included are real examples coming from Operating Units in countries such as: Brazil, Colombia, Dominican Republic, Malaysia, Pakistan, Philippines, South Africa and Uganda.

### Tool Box Meetings

Tool Box Meetings (TBMs) are especially relevant for first line supervisors responsible for a team of workers. The open discussion of Safe and Unsafe Behaviours, *Potential Incidents* and foreseeable *consequences* plays an important role in raising HSE awareness at the sharp-end. HSE Tips should also be discussed during these meetings. Tool Box Meetings should also be held before employees start their working day.

### Contractor Audits

These play an important role in contractor HSE performance improvement, especially if a scoring system is used allowing the results to be quantified (e.g. up to a maximum of 100 points). They should be periodic (e.g. every quarter) and signed by both parties (company and contractor). A Remedial Action Report should also be added and signed by the parties involved.

### Management Facility Visits

An important way to proactively involve top management of the company with top management of contractors. This is especially relevant when done on a 'Partnership' basis with the objective of overall HSE performance improvement. These visits acquire special relevance when they immediately follow periodic audits.

### Driver League System

This powerful tool for increasing drivers status and road transport safety performance should involve driver classification (e.g. up to a maximum of 100 points) and be supported by two tables of merit and demerit points. These are usually different from company to company as they are influenced by the local environment. These classifications are used to place drivers in one of several (normally 3 or 4) categories reflecting their safety performance and awarding them status accordingly. This works much better than the absolute ranking of drivers in a league table, in which the only person who is really happy is the first, and those lower down the ranking have little incentive to improve.

The drivers league system is exclusively related to personal commitment and self responsibility for HSE.

### Team (e.g. Drivers) Behavioural Performance System

A very powerful tool for raising team safety performance. It involves monitoring a list of crucial safe / unsafe behaviours performed by team members. An adequate measurement (e.g. up to a maximum of 100%) of these behaviours, which emphasises particularly important behaviours, encourages continuous performance improvement.

### Contractors (e.g. road contractors) League System

A powerful tool for increasing HSE Contractor performance. It involves contractors' classification (e.g. up to a maximum of 100 points) and should be supported by audits where final evaluation should take into account drivers performance. These audits can again be different from company to company taking into account the local environment.

### HSE Management System

This is the overall system that with an adequate supply of proactive energy and the related

effective strategies continually improves HSE performance.

## HSE Case

A 'living' demonstration that an HSE Management System exists and focuses on risks being continuously reduced to ALARP levels. An HSE Case is required for all 'HSE critical' activities.

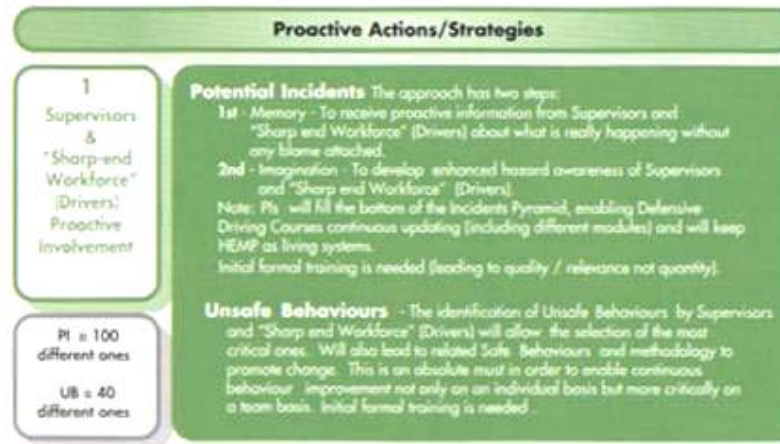
## Setting Targets and the 'Knock on' effect

As we have seen, the *Strategic Blocks* are usually divided into two main groups. Targets should be established for each *Strategic Block* so performance can be measured. The examples in 5.35 – 5.40 illustrate proactive targets successfully used by real Operating Units. The first group (5.35/36/37) should ensure:

- Proactive involvement of all levels of the Company or Contractor, from sharp-end workforce level to top level management.
- Support of the overall strategy
- The right sequence of Strategic Blocks that lead to systems (second group)

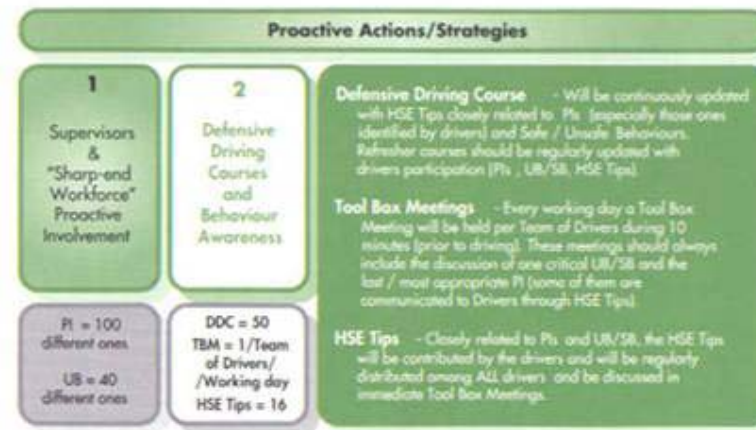
The second group of *Strategic Blocks* is there to make sure that a system or systems are in place for the continued improvement of HSE performance (5.38).

### Real Example Road Transport - 1st Proactive Strategic Block 5.35



Note: PI = Potential Incidents, UB = Unsafe Behaviour

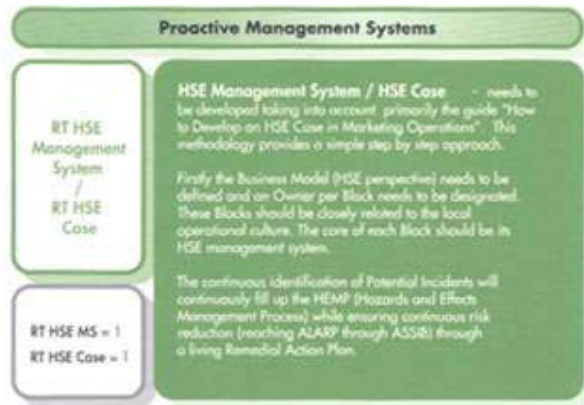
### Real Example Road Transport - 2nd Proactive Strategic Block 5.36



Note: PI = Potential Incidents, UB = Unsafe Behaviour, SB = Safe Behaviour, DDC = Defensive Driving Course, TBM = Tool Box Meeting

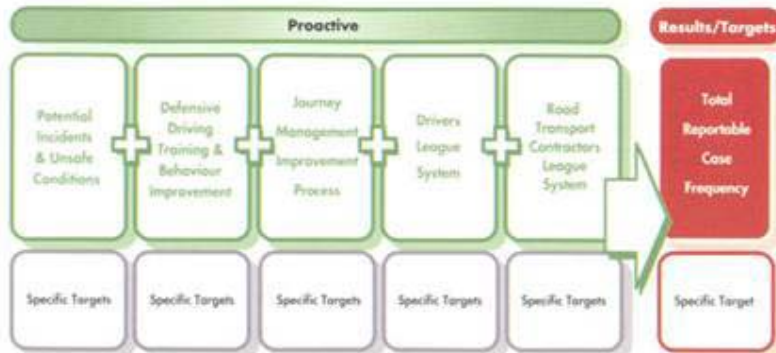
The initial sequence of *Strategic Blocks* should create a 'knock on' effect towards the second group of *Strategic Blocks* (5.39/40). This should ensure that there will be proactive and 'living' Management Systems and HSE Cases in place.

Real Example Road Transport - Final Proactive Strategic Block 5.38

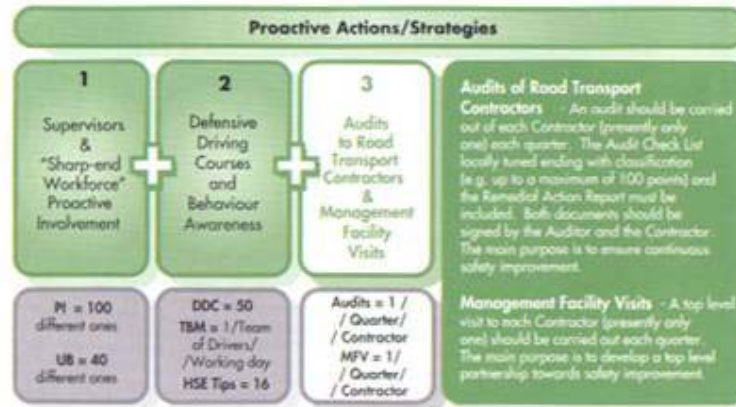


Note: PI = Potential Incidents, UB = Unsafe Behaviour, DDC = Defensive Driving Course, TBM = Tool Box Meetings, MFV = Management Facility Visits, RT = Road Transport, ALARP = As Low As Reasonably Practicable, ASSBI = Real Time Stop In System

Example Road Transport 5.40

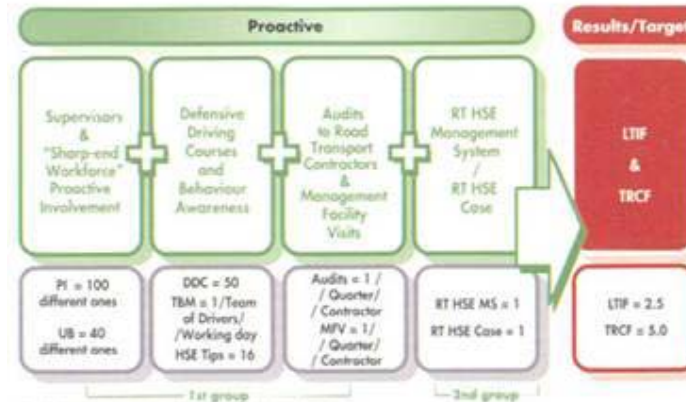


Real Example Road Transport - 3rd Proactive Strategic Block 5.37



Note: PI = Potential Incidents, UB = Unsafe Behaviour, DDC = Defensive Driving Course, TBM = Tool Box Meetings, MFV = Management Facility Visits

Real Example Road Transport 5.39



Note: PI = Potential Incidents, UB = Unsafe Behaviour, DDC = Defensive Driving Course, TBM = Tool Box Meetings, MFV = Management Facility Visits

## 6 Weighing the Scorecard and establishing the Corporate Link

Having established proactive targets for each of the Strategic Blocks as described in Section 5, we can incorporate proactive and reactive HSE performance in to the Scorecards used for the appraisal of staff. This is best approached on a step-by-step basis by:

- weighing the importance of each *Strategic Block* to arrive at an overall measurement of Proactive HSE performance
- weighing the relative importance of the Proactive (Internal Perspective) and Reactive (External Perspective) performance measurements
- weighing the importance of HSE along with other performance measurements in the departmental scorecard
- finally establishing the 'Corporate Link' to ensure responsibility for HSE is proactively shared

### Weighing the Strategic Blocks

Examples 6.1/2 illustrates how to weight the strategic blocks, as further described on page 24.

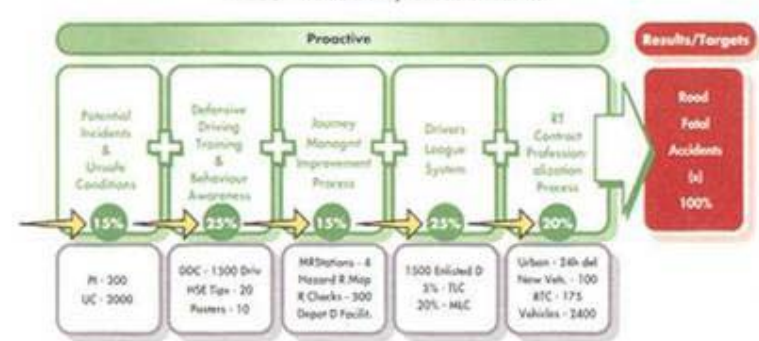
Now that targets for *Strategic Blocks*, and any related actions and HSE indicators have been established in the Scorecard, we can determine the weighing (importance) of each *Strategic Block* – together they should equal 100%. See the real examples (6.1/2).

A similar process should be followed if there is more than one reactive target in the scorecard. We now have a Scorecard that includes the desired reactive targets (the External Perspective) and the proactive actions needed to achieve these targets (the Internal Perspective). The next step is to establish the relative importance (weightings) of these reactive and proactive performances.

### Weighing the Perspectives

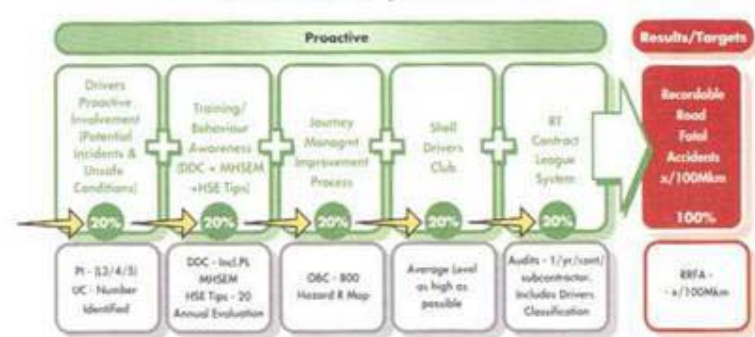
The weighing between the Reactive and Proactive Indicators for the Internal and External Perspectives will change depending on the seniority of the personnel concerned (6.3/4). For

Real Example Road Transport Scorecard 6.1



Note: UC = Unsafe Conditions; RTC = Road Transport Contractor; MRS = Midway Rest Stations; D = Driver; TLC = Top Level Category; MLC = Medium Level Category; h = hour; del = deliveries

Real Example Road Transport Scorecard 6.2



Note: PI = Potential Incident; UC = Unsafe Conditions; DDC = Defensive Driving Course; MHSEM = Monthly HSE Meeting; OBC = On Board Computer; RT = Road Transport; RRFAs = Recordable Road Fatal Accidents

the top management of the Operating Unit, the weighing is usually based 100% on the external perspective, ie the chosen Reactive Performance Indicators. At line management level in the External Perspective (setting goals and targets), the weighing can be as high as 90%, while in the

Internal Perspective (the actual actions and systems required to achieve the goals and targets) the weighing can be as low as 10%. In the same way, the External Perspective for the sharp-end workforce can be as low as 10% while the Internal Perspective can be as high as 90%.

It is particularly important that the performance of the line management team is principally measured using the proactive HSE performance indicators (for example >70% on the proactive indicators).

### Weighing the Department Scorecard

Once the perspectives have been weighted, HSE Performance can be incorporated in the Department Scorecard. The importance of HSE is directly related to its Scorecard Percentage (6.6). With this final weight, the Scorecard becomes complete (6.7).

### The Corporate Link

The 'Corporate Link' (6.8) is achieved when responsibility is proactively shared at all levels of the company and contractors. This helps create a shift from self-responsibility to shared responsibility.

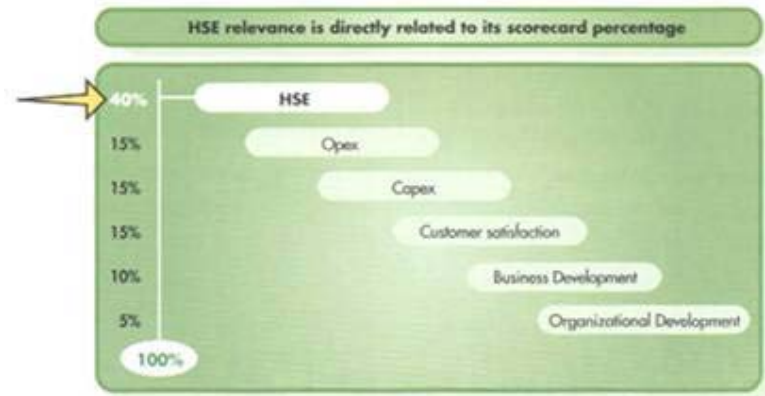
As an incentive, the HSE performance should be linked to every employee's annual bonus and based on achieving desired targets. Having Operating Units and contractors working together

towards HSE performance goals, especially on a 'Partnership basis', creates powerful motivation to achieving desired goals.

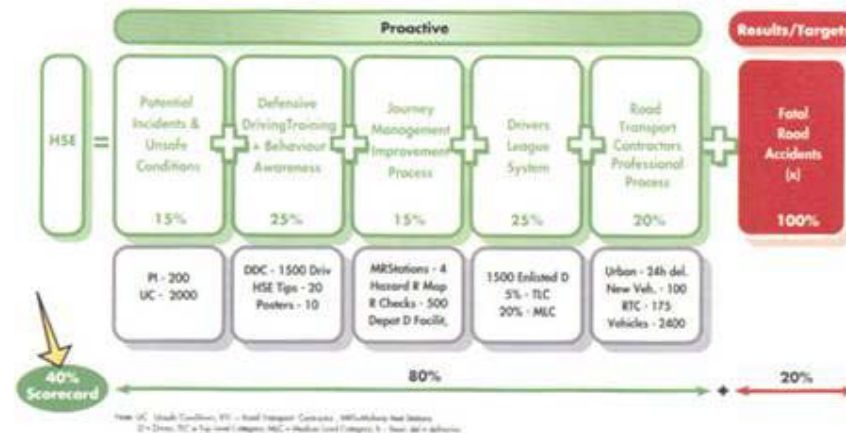
By connecting everyone, this approach creates 'peer pressure', a very important tool at all levels.

The relationship between Operating Units and contractors is certainly an important aspect to achieving a Proactive HSE Culture.

Example Distribution Department Scorecard 6.6



Real Example Road Transport Scorecard 6.7



From UC - Unsafe Conditions, RTI - Road Transport Contractors, MR - Multiple Road Incidents, TIC - Train, TIC - Top level Category, MLC - Medium level Category, V - New, MR - Rail Station

## 7 Monitoring progress and audits

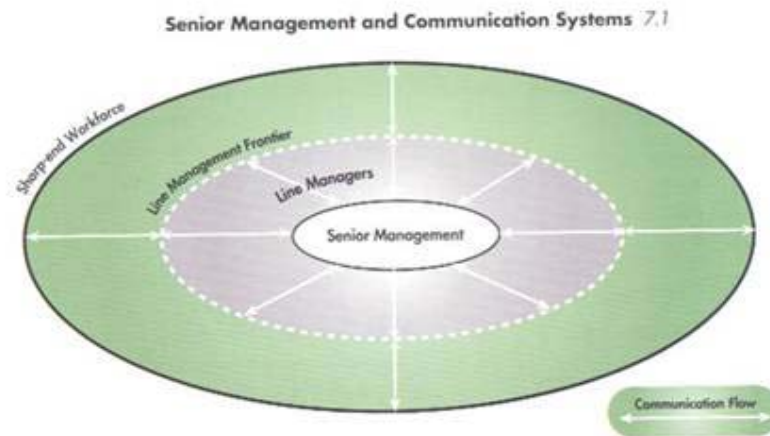
*To monitor progress towards departmental targets and proactive strategies, an effective information system needs to be put in place that focuses mainly on proactive HSE actions and HSE Performance Indicators. This system will demonstrate internal and external HSE performance improvement. An audit plan should also be put in place to ensure the reliability of the system.*

As a Proactive HSE Culture develops, effective monitoring and information systems play an increased role towards measuring behavioural performance. However, it's important that these monitoring systems retain the trust and confidence of the sharp-end workforce.

A Proactive HSE Culture relies heavily on gathering appropriate information through a 'no blame' approach to reporting and requires active encouragement by first line supervisors who have to manage the vital interface with the sharp-end workforce at the 'line management frontier'.

### Communication and Senior Management

Communication is a vital ingredient in an Effective Proactive HSE Culture (7.1). The ultimate responsibility for the success of a Proactive HSE



Culture lies with management at departmental level. It is their responsibility to communicate on a regular basis the overall performance, positive and negative, of the department. As the culture develops, the sharp-end workforce should begin to take more responsibility for its action, but senior management support remains essential.

Senior management also need to ensure that information on HSE is relevant to the local situation and reaches the appropriate people. This type of information includes:

- Potential Incidents
- Safe and Unsafe Behaviours
- Incidents (near misses or accidents)

- Other relevant incidents involving other companies in the same region or country
- Special term results/rewards

HSE Tips are a very good way to do this, so it's essential that first line supervisors and the sharp-end workforce receive them on an appropriate basis. Sending the right messages

at the right time will enhance the effectiveness of the HSE Tips.

### Communication and Line Management

Line Management, particularly those first line supervisors (line management frontier) working directly with the sharp-end workforce, must play a very proactive role in the chain of communication and are always involved in any *Potential Incidents*, Safe and Unsafe Behaviours, HSE Tips, Audits and Training.

Without them, developing a Proactive HSE Culture is not possible. Their relationship with the sharp-end workforce is fundamental to effecting a change from a traditional reactive culture to a

proactive one. It's crucial that they have the support of Senior Management if they are to earn the respect of the sharp-end workforce.

As leaders of their own local units, they are the driving force behind any HSE proactive and reactive performance improvement. An essential part of this improvement is enhancing Safe Behaviours on a team basis.

### **Communication and the Sharp-end Workforce**

It's a well recognized fact that around 90% of accidents are caused by human error at the sharp-end. These accidents can lead to significant financial loss, even bankruptcy, for some companies.

With this in mind, effective communication to and from the sharp-end of the workforce is vital. Tools such as Unsafe and Safe Behaviours, *Potential Incidents* and HSE Tips allow all workers, not just those in management, to contribute proactively to performance improvement. This implies an increase in Safe Behaviour performance across the sharp-end workforce and contributes greatly towards overall success.

It's true to say that without the commitment and proactive involvement of the sharp-end workforce, an HSE Management System or HSE Case will

never deliver a breakthrough in HSE performance, in either the company or within contractors.



## 8 The Performance and Effectiveness Diagram

To measure program, it's important to evaluate the effectiveness of a Proactive HSE Culture. This can be illustrated through the Performance and Effectiveness Diagram (8.1) that shows the simple relationship between reactive (external) perspective performance and proactive (internal) perspective performance. The diagram includes:

- Proactive Performance
- Reactive Performance
- Proactive Energy Effectiveness

The Proactive Performance (-20% to + 120% in example illustrated) represents the performance against the established proactive targets.

The Reactive Performance (-20% to + 120% in example illustrated) represents the performance against the established reactive targets.

Finally, the Proactive Energy Effectiveness is simply the relationship between the Reactive and Proactive performances.

To calculate the Proactive Energy Effectiveness, divide the Reactive Performance by the Proactive Performance. The ideal result would be 100%.

A Performance & Effectiveness Diagram may be used continuously by the department or team to identify:

- The amount of proactive energy (i.e. as demonstrated in Strategic Blocks) needed to achieve specific targets.
- The need for intermediate corrections.
- The effectiveness of different strategies.

Example **Performance & Effectiveness Diagram 8.1**



## Conclusion

### The Self-Sustaining HSE Stage

An Effective Proactive HSE Culture has:

- Commitment and proactive involvement from senior management
- Proactive involvement from line management including first line supervisors
- Personal motivation, responsibility, ownership and empowerment of the sharp-end workforce
- Team HSE performance and shared responsibility.

If each of the above is present, then the company will have a continuous 'learning culture' where the abilities and experience of sharp-end workforce, and the coaching capacity of first line supervisors, are highly respected. Developing trust and confidence is essential to reach this culture.

As an Effective Proactive HSE Culture grows it leads to solid improvements in HSE performance and will eventually reach the 'Self-Sustaining HSE stage'. This is when the shift in culture is complete and HSE is highly regarded, actively sought, promoted and rewarded throughout the organization. In short, HSE considered a major part of the business.

### Extending and integrating this approach into other business areas

It is possible to extend this approach to other business areas such as quality and productivity.

For example, Quality Management is based on the principle of Plan, Do, Check, Act and leads to continuous quality improvement. When this process is applied across a company, it leads to Total Quality Management – where everyone shares the responsibility for quality. To do this effectively, quality standards need to be maintained throughout the entire process, and at all levels of the company.

The Effective Proactive HSE Culture has exactly the same approach, and both could benefit from each other's simultaneous implementation.

Scorecards (the measurement & reward of the proactive strategies and actions) play a vital role in an Effective Proactive HSE Culture. These vital tools can be applied with equal success to other areas of the business.

### Final comment

Some Operating Units are undoubtedly moving towards an Effective Proactive HSE Culture and intermediate results are showing this to be true.

Nevertheless, there is still a significant way to go. Achieving an Effective Proactive HSE Culture takes a lot of hard work and fine-tuning. There are many different aspects that need to be considered, enhanced and developed. Opposite is a list of the main requirements:

- Leadership
- Co-ordination
- Vision
- Overall long term strategy
- Appropriate annual strategies
- Annual proactive energy
- Correct tactical moves
- Scorecards
- Effective reporting system (including 'no-blame' approach)
- Adequate information system
- Adequate communication system
- Team performance
- The Corporate Link
- Frankness
- Trust

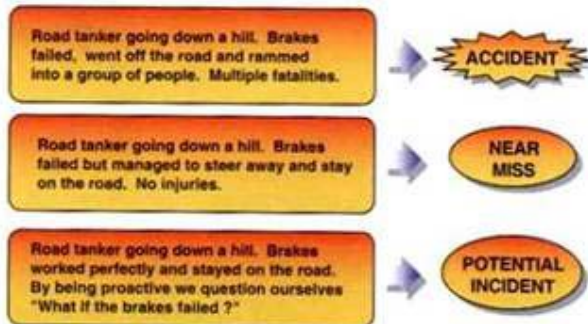
- Confidence
- A proactive 'living' HSE Management System
- A proactive 'living' HSE Case (if required)

**We need to ask ourselves if the effort is worthwhile.**

*There's only one answer...*



Picture these scenarios...they may help us save lives !!



Potential Incident is defined as a relevant, realistic imaginative scenario that is likely to happen with potential to cause harm, damage or both.

Accident does not simply happen by itself. It is often caused by people's actions or its omission. Let us pause from our work and reflect..

- " Are they any Unsafe Acts and Conditions in our surrounding environment?"
- " What if the unexpected happens ?"
- " Is there a better way of doing things ?"

**NEXT (Part 2), THE "PYRAMID" WILL SHOW US WHY....**

No Customer Service Without Safety  
**KITA BOLEH!**

Shifting the **Incident Pyramid**...



By identifying and addressing Potential Incidents we should be able to reduce the pyramid to the Potential Incidents Zone and subsequently eliminate or reduce the chances of an accident which may cause injuries or death.

This is the Proactive approach of preventing accidents, ( i.e. preventing accidents **BEFORE** they happen ) instead of the old and unsuitable Reactive approach ( i.e. reactive approach takes preventive measures only **AFTER** an accident has happened and lives have been lost ! )

No Customer Service Without Safety  
**KITA BOLEH!**

This is the **Incident Pyramid**...



Studies have shown that for every ( 1 ) fatality, there are 600 near misses ( actual events with no injuries or damages ). And out of these near misses , there could have resulted in 30 accidents, 10 of which would be of the injurious type. But behind these misses, there are also more than 1000 Potential Incidents !!

By identifying these Potential Incidents and addressing them, we are preventing accidents that may have disastrous or fatal consequences !! A simple way of identifying Potential Incidents is by using our imagination and asking the question "What if...?" for every action or task that we or others do ( e.g. *What if the brakes fail when the road tanker is going down the hill ?* )

**HOW DOES THIS COME ABOUT ?? TO BE CONTINUED NEXT ISSUE (Part 3)...**

No Customer Service Without Safety  
**KITA BOLEH!**

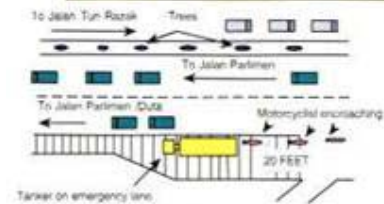
# HSE TIPS Potential Dangers!!

On the night of 09.08.1997, one of our tanker drivers had parked his lorry on the emergency lane along Jalan Mahameru near PWTC. He was suffering from an uncontrollable stomach upset and left his tanker unattended to ease himself. The engine and all lights were switched off. **The hazard lights were not switched on and neither was the reflective triangle displayed.**

This potential incident is very similar to an earlier accident this year when a Singapore tour bus rammed into the rear of a lorry parked unmarked at the emergency lane near Nilai causing multiple fatalities.

In our renewed commitment to HSE of pursuing the goal of no harm to people, all employees including BDEs, BDMEs, hauliers and drivers are encouraged to continue to carry out **On The Road Performance Checks** so that an ugly accident of this nature will not recur. Worksites had since held extensive tool box meetings to brief all drivers the potentially fatal implication of such an incident.

- ⚠ Switch on HAZARD LIGHTS
- ⚠ Display REFLECTIVE TRIANGLE & CONES



No Customer Service Without Safety  
**KITA BOLEH!**

# HSE TIPS UNIFORM

moving towards a proactive safety culture

Shell haulier drivers are gearing towards becoming professionals. A Professional, amongst other things, must be disciplined in their personal appearance & apparels. Therefore uniforms identifies the professional group to which we belong.

### WHY WEAR UNIFORMS ?

- ☑ IT TELLS PEOPLE THAT WE ARE TRAINED, RESPONSIBLE, DISCIPLINED & A RESPECTABLE SPECIAL GROUP OF DRIVERS
- ☑ IT TELLS PEOPLE WHETHER WE ARE CLASS A, B OR C DRIVERS THROUGH THE EPAULETTES (STRIPES)
- ☑ IT IDENTIFIES US AS ROLE MODELS TO OTHER DRIVERS IN THE PETROLEUM INDUSTRY OR OTHER INDUSTRIES
- ☑ IT PROVIDES PROTECTION e.g. long sleeves uniform for bitumen drivers to protect their hands & arms

*Please get your uniform from your haulier if you do not have any yet.*

### What if I do not wear the uniform ?

Our hard earned KPS points will be deducted if we are seen driving without a uniform.

No Customer Service Without Safety  
**KITA BOLEH!**



You enjoy the world only if you are ALIVE. Safety is for YOUR well being and protection

## Attention , Unsafe Behaviour



## Safe Behaviour



- Ensure through the Rear View Mirror that no child or person is around the Tank Lorry.
- Always keep the valves covered.

**Think Twice...  
put *Safety* first:**

**THIS WEEK'S SAFETY TIP!**

**When driving your truck,**

- drive DEFENSIVELY
- stick to the speed limit at all times
- only drive at the speed limit if it is safe to do so
- always obey road traffic signs
- always obey traffic lights, do not "jump" lights when on amber
- be prepared to stop even if the light is green, in case someone makes a mistake
- keep a safe following distance from the vehicle in front of you
- use your mirrors frequently to be aware of what's going on around you
- if you go off the road by accident, try to stop instead of swerving back
- on long trips, take a break at least every 2 hours

**TIPS FOR HEALTH & SAFETY ENVIRONMENT**

You enjoy the world only if you are **ALIVE** Safety is for YOUR well being and protection

**SAFETY TIPS TO SAVE YOUR SELVES FROM EXTREME HEAT**

**Friends!**

**With the advent of Summer, a few important safety points to follow:**



- Do not work for long periods in the sun & extreme heat.
- Wear loose cotton clothing.
- Drink reasonably cool & clean water. This should be approximately 6-8 glasses of water in addition to your normal intake of tea. In case of heavy work this should be increased to more than 6-8 glasses.
- During a 24 hour journey, do not drive continuously for more than 4.5 hours, and your total day/night driving should not exceed 10 hours.

To win a reward please retain this leaflet.

**Health Safety Environment Security Tips**

**Food for Thought**

That simple Attribute of the Driver is what counts Most :

**Good Manners and Right Conduct**

*The phrase "Good Manners and Right Conduct" is no longer new to us. These words could have registered into our minds since childhood. This popular saying could have been imparted to us by our parents at home, and/or our teachers in school. Words which does not require analytical thinking to grasp mentally, so straight forward, so simple to understand. Yet, in its simplicity, people would tend to ignore, neglect and forget.*

*If it so happens that "Good Manners and Right Conduct" had already slipped our minds, perhaps it's not yet late to learn it once again. Amidst the multitude of the things that we acquired, and continue to acquire, at home, in school, since the start of our existence, this Good Manners and Right Conduct is one of those attributes that we should cherish. Wherever, in our daily dealings and in through course of our life, even when driving, this Good Manners and Right Conduct is something that we should not miss, something we should keep Always.*

**Conduct**

With respect to general conduct, drivers shall :

- follow procedures regarding DUTY HOURS and REST PERIODS
- follow defensive driving principles and techniques
- wear seatbelt at all times while in a moving vehicle
- work in accordance with all the HSE rules and to act on the instructions of their supervisor
- keep the vehicle and cab interior clean and tidy
- not place heavy or sharp objects in the cab (or on top of the tank shell)
- not place product contaminated materials, including gloves, in the cab
- not engage in horseplay or unsafe driving maneuvers
- not drive while under the influence of alcohol and drug
- not carry any passengers other than approved helpers and supervisors
- not smoke or carry matches, lighters or other source of ignition when carrying flammable products



## Long Haul Journey

5.21

*moving towards a proactive safety culture*

The hauliers in Shell are professional transporters. And managing safety is an integral part of their daily routine. Hauliers must be very much involved in managing the drivers in all aspects especially in Health, Safety and Environment. Some deliveries to distant customers, a round trip of more than 500 Km, need careful journey management. In these long haulage, hauliers roles are the primary influential factor.

- ☺ FOLLOW JOURNEY PLAN (AS AGREED BY SHELL)
- ☺ FOLLOW SHELL DRIVING AND DUTY HOURS (WORKING TIME & HOURS)
- ☺ PREPARE PROPER SHIFT ROSTER THAT ENSURES DRIVERS GET ADEQUATE QUALITY REST
- ☺ DAILY TOOL BOX MEETING WITH DRIVERS BEFORE TRIPS & REMINDER ON DEFENSIVE DRIVING COURSE NIGHT DRIVING TECHNIQUES, RESTING TIME & UNAUTHORIZED ROUTES
- ☺ PROVIDE DRIVER WITH MOBILE PHONE & HANDS FREE KIT FOR EASY CONTACTS
- ☺ HAVE LORRY MAINTENANCE ARRANGEMENTS WITH SOME CONTRACTORS ALONG THE ROUTE
- ☺ ENSURE LONG HAUL LORRIES ARE AIR CONDITIONED & FITTED WITH A RADIO



No Customer Service  
Without Safety  
**KITA BOLEH!**

Illustration by DDM Team - Dr. Arindita, Luciana & Diana, 3 December 1987

## Dicas & Segurança

5.23

### ASSAULT: HOW TO PROCEED ?

#### General procedures:

- Don't argue or react;
- Be calm and avoid fast movements;
- Avoid looking at the thief;
- The important thing is not to get hurt.



Remember that the attackers are under emotional tension and most of the time, under the influence of drugs.

#### Communications:

- ☎ Call the police.
- ☎ Call the depot manager.

## Dicas & Segurança

5.22



### FOG

- + Slow down the speed and turn on low light;
- + Use visual supports ( road markings, lighting and break lights of the car ahead );
- + Indicate everytime you will change lane;
- + Don't overtake and don't drive too close to the vehicle ahead;
- + Don't use flash lights;
- + If the fog gets strong, stop and wait in a safe place.

• Avoid stopping on the road, even if it's on the shoulder. Do it only if you don't have any other option. In this case, turn on the flash light and place the red reflective warning triangle 40 feet far.

#### Remember:

- In situations with poor visibility, the important is to see and to be seen.
- In an emergency, if you have to stop on the road, you can also use branches of trees to signalize.

03/99

# Health Safety Environment Security Tips



## Certified VIP (Very Important Procedure) Use of Delivery Checklist



In accordance with the memorandum issued by Shell last February 7, 1999, accomplishment of Lorry Delivery Checklist for every delivery to customer is necessary. Therefore the driver, together with the authorized receiver of the customer, will have to accomplish and sign on the delivery checklist for every delivery.

The accomplished and signed delivery checklist is an assurance that the product was delivered by the driver and received by the customer in good condition. It ensures that the delivery is in accordance to what is stipulated in the delivery invoice i.e. quantity and quality, and that the standard procedure, taking into account safety and security, in discharging/unloading petroleum product into the customer's site has been followed.

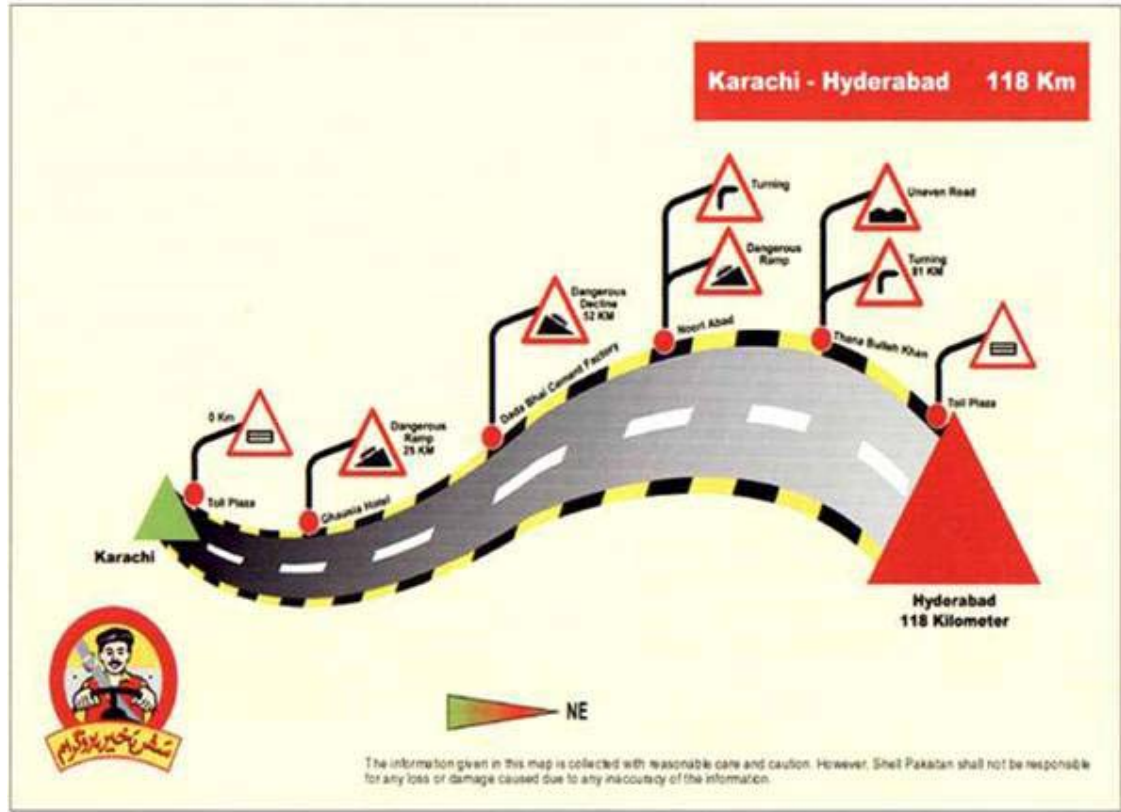
The delivery checklist is also a tool in soliciting feedbacks and suggestions from customers on how Shell can improve Customer Service.

We are all aware that accomplishing delivery checklist would mean additional task on the driver, however if we are to balance the value of doing it, we will realize that the advantage of accomplishing this document is more than worth the effort.

Delivery Checklist Question Items	
1. Is the lorry on level ground, away from sources of ignition?	11. After inspection, has the lorry parked safely and repaired the discharge point?
2. Does the driver have valid ID?	12. Is the lorry/vehicle engaged and are checks placed?
3. Is the delivery document in order?	13. Is the Fire Extinguisher accessible placed in case of emergency?
4. For CDD deliveries, is the cheque ready?	14. Does the lorry have enough oil/gas?
5. Are the serial number of tanks the same as what is indicated in the invoice?	15. Is the discharge hose connected to the correct IS appropriate line?
6. Are the tanks closed, not damaged, or broken?	16. Are hose connections in good order, no leaks during discharging?
7. Is the lorry calibration still valid?	17. Are the compartments completely empty after discharging?
8. Are the compartments filled up to the bottom side of safety marker?	18. Have the lorry valves and hoses been inspected after discharging?
9. Have samples been taken from all compartments to check for color, odor, contaminants and presence of water?	19. Has the hose been properly disconnected & area liberated for steps?
10. Is the issuance of discharging agreed?	20. If applicable, is in order, has the payment been given to the driver?
	21. Are all documents accomplished?
	22. Has the correct copy of document been given to customer?



Approve key Manager kung may Delivery Checklist Akong mag deliver!





ON THIS SPRING BREAK REMEMBER THAT SOME USERS OF THE ROAD MIGHT BE UNDER THE INFLUENCE OF ALCOHOL.



**YOU, A DEFENSIVE DRIVER, SHOULD BE ALERT AND BE CAREFUL TO PREVENT UNDESIRED SITUATIONS.**

APRIL 6, 1999  
WEEK NO. 16  
DOMINICAN REPUBLIC



**HSE TIPS** **Fasting Month**  
*moving towards a proactive safety culture*

Fasting month is here again. It is a time for great sacrifices. However these sacrifices do not include compromising our safety and that of others. Fasting may cause a person to be inattentive. Excess sweating because of physical work and heat from the surroundings may aggravate the effect of fasting on one's alertness and very often may cause sleepiness especially in hot afternoons.

**THEREFORE**

- ☺ AVOID EXCESSIVE MEALS WHEN WE "BERSAHUR" BECAUSE HEAVY MEALS WILL CAUSE SLEEPINESS
- ☺ HAVE MORE FREQUENT STOPS
- ☺ BE CAUTIOUS !! OUR OTHER MUSLIM FRIENDS WHO ARE FASTING. MAY ALSO BE ON THE ROAD



**SELAMAT BERPUASA**

No Customer Service  
Without Safety  
**KITA BOLEH!**

Illustration by ZDM Team for workbooks, newsletters & others - © January, 1999

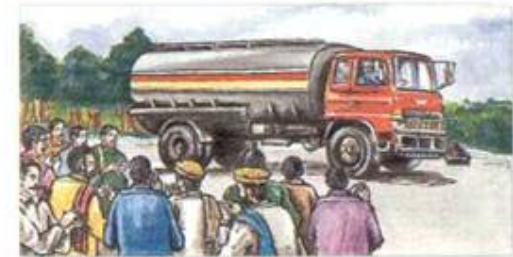
**Shell** **TIPS FOR HEALTHY ENVIRONMENT**  
You enjoy the world only if you are **ALIVE** Safety is for YOUR well being and protection

" He who saves life of one human being saves mankind"

**Well-done!**

Shell contract lorry drivers.

Since February 4, 1999 to date, for the last **35** days, there have been **no fatal accidents.**



God willing, together we will continue to keep up our good performance and strive to be even better.

January 1999

01/99

**Safety for Self - Safety for All**



**Shell Drivers Great Achievement**

**75 Days**

**without a fatal accident**

Shell  
**HSE TIPS**

**WE HAVE DONE IT!!**

*moving towards a proactive HSE culture*

Today the 1st of July 1999, we have had no Lost Time Injuries (which also means no Fatal Accidents on the road) for a continuous period of 12 months. This achievement would not have been possible without your commitment towards safety on the road.



**GOOD NEWS !!**

".. you have my full support in order to enable Shell Uganda to prove that breakthrough road safety performance is possible in Africa". *Jose Cardita Group CEO/2*

**MORE GOOD NEWS !!**

".. it is fair to say that we made quite some progress on the issue of road safety. With more work to do in the near future, I am confident that we will make our ambitious target". *P.P.M. Nass Managing Director, Shell Uganda.*

**Learn from others mistakes - The result of negligence and speeding is in front of us.....**



We can prevent such accidents if we familiarise ourselves with emergency procedures and adhere to them.



A fatal accident took place near Zhang on 16th May in which more than 100 persons were burnt to death.



No. 02-99

**HSE UNIT**

**LEARNING FROM THE ACCIDENTS**



**ACCIDENT** Leaving the facilities, while making a left turn, the trailer of a motor truck casted off leaning dangerously on one of its sides.

There was a partial loss of the load.

**ROOT CAUSES**

- ↳ Fifth wheel locks break due to a bad reparation.
- ↳ Unfinished safety inspection.
- ↳ Poor safety awareness of the driver.

**LEARNING FROM THE ACCIDENT**

- Vehicle safety inspection should include an overall mechanical inspection.
- Driver training should emphasize on perfect vehicle operating conditions.
- To have a successful emergency control, taken actions should be steady, fast, and coordinated.

**We should be aware that vehicle maintenance is essential and it should be given prior attention. Your life also depends on it.**



**HSE TIPS**

**SAFE DRIVING BENEFITS ALL!!**

moving towards a proactive safety culture

Pub. (1)



Lucky escape for dazed tanker driver

**Friday,  
10 July 1999,  
A day driver,  
Lim Seng Peng,  
aged 35, would like  
to forget, but will  
always remember...  
here's his story  
in his own  
words...**



*My Poorest Experience...*

I was driving my lorry along the KL Seremban expressway about 3 km from Ateit to a customer in Rawang. I had a collision with a lorry in front of me. I tried to jam the brakes but it was too late. There was a loud bang and my lorry went out of control. The lorry tilted over and landed on its side on the outer lane of the highway. And as I slipped into unconsciousness, my whole life flashed before my eyes...

A passing motorist sent me to the hospital. I woke up hours later, only to find myself at the Seremban General Hospital. There was a splitting pain in my head and I was given 10 stitches. My condition was stable, but I was watched for 24 hours for observation.

I was shocked when I saw pictures of my wrecked lorry, which was extensively damaged with two burst front tyres. I was lucky to be alive! Tears welled up in my eyes as I saw my wife and three children. They clung to me tightly, as if they were afraid to let go.

*What saved me?*

The safety belts, of course! Most times, I used to pull the belt across without strapping it firmly in place. That day, as if there was a voice within me telling me to strap it firmly in place, I did just that. I do something I should have done always, I know I will from now on.

**My friends, and I know many of us,  
who take this little act of safety for granted,**

**Please strap up,  
it might cost you  
your life!!!**

Our Customer Service Without Safety  
KITA BOLEH!

Prepared by OSHA Team for workers, hauliers & drivers. 27 August 1999



**HSE TIPS**

**Many Incidents This Week**

- Two vendors died and thirteen others injured in a bomb blast at Old Taxi Park on 10/04/99.
- Trucks KAJ 485Z and KAG 390U driven by Waiguru and Kamunyu respectively were found parked dangerously along 7th Street among "somali" trucks on 12/04/99
- M/V 680 UDA of RWAMS, having loaded for Arua at 5.00pm was found in a Makindye garage at 6.00pm on 14/04/99.
- M/V UAA 845K driven by Karekezi offloaded AGO into a BIK tank on 15/04/99 at S/Kawempe. The driver had left turn-boy to offload.

**Learning points;**

- Avoid congested gatherings and abandoned parcels.
- Avoid the "somali" uncontrolled parking on 7th Street.
- Avoid scheduling to travel at night. Uncontrolled activities in garages include welding that may ignite the tanker.
- Follow discharge instructions; and attend to unloading tanker without leaving the turn-boy in charge.

Source: The World's Largest Oil and Petroleum Company. Shell Oil Refineries and Marketing. 1998, 1999 & 2000

## Abbreviations

**AFI** = Area For Improvement

**ALARP** = As Low As Reasonably Possible

**Capex** = Capital Expenditure

**DDC** = Defensive Driving Course

**H** = High

**HEMP** = Hazards and Effects Management Process

**HSE** = Health, Safety and Environment

**KPI** = Key Performance Indicator

**L** = Low

**LTI** = Lost Time Injuries

**LTIF** = Lost Time Injury Frequency

**M** = Medium

**MFV** = management Facility Visit

**MS** = Management System

**Opex** = Operational Expenditure

**OU** = Operating Unit

**PI** = Potential Incident

**RAM** = Risk Assessment Matrix

**RT** = Road Transport

**SB** = Safe Behaviour

**TBM** = Tool Box Meeting

**TRCF** = Total Reportable Case Frequency

**TROIF** = Total Reportable Occupational Illness Frequency

**UB** = Unsafe Behaviour

**UC** = Unsafe Case

## Glossary

**Accident** = Incident causing actual damage or consequences to business (people, assets, environment or reputation).

**Consequence** = Quantifiable effect / escalation of effects leading to damage (people, assets, environment or reputation).

**Hazard** = The potential to cause harm, including ill health and injury, damage to property, products or the environment, production losses or increased liabilities (or a system where energy – in single or combined form – is able to trigger an incident with undesired consequences if the occurrence of a given threat is not prevented or controlled).

**Hazardous Scenario** = Any foreseeable, credible and undesired hazardous event linked to a hazard.

**HEMP** = Risk methodology consisting of 4 stages: Identify (Hazards and Potential Incidents), Assess (Risks, using the Risk Assessment Matrix), Control (Threats), Mitigate / Recover (Consequences).

**Latent Failure** = Structural or organizational weakness that may open 'window' for future field incidents.

**Near Miss** = Incident with no actual damages / consequences to business (people, assets, environment or reputation).

**Potential Incident** = Relevant, foreseeable, credible and undesired hazardous event (If the event is a hazardous one, it will lead to HSE business issues. If the event is a non-hazardous one it will lead to non-HSE business issue) with foreseeable and quantifiable consequences, from which HSE lessons can be learned by interested parties.

**Risk** = The product of the probability of the occurrence of a given hazardous event (with related consequences) by the severity of the related consequences.

**Risk Management** = The process of selecting the most cost-effective measures for achieving the desired risk reduction.

**Strategic Block** = Group of internal proactive actions and / or internal proactive HSE indicators with related targets.

### **References**

Group Procedure for an HSE Management System – March 1997.

How to Develop an HSE Case in Marketing Operations – November 1998.

HSE Management System – September 94.