Joint ECTA-EPCA-CEFIC Working Group

GUIDELINES FOR SAFETY AWARENESS AND BEHAVIOUR IN THE SUPPLY CHAIN

Responsible Care

ISSUE 1 • April 2002

Guidelines for Safety Awareness and Behaviour in the Supply Chain

ISSUE 1 - April 2002

CONTENT OF BOOKLET

SCOPE

Safety behaviour across the whole supply chain (hauliers, loading and unloading points, terminals etc).

OBJECTIVES

To identify/promote best practices and techniques to increase safety awareness and safe behaviour.

To identify/promote best practices in communicating/sharing the learning.

To suggest ways to implement.

INTRODUCTION

Many companies have learnt that the key ingredient to developing a “best in class” safety record is not only through having adequate equipment, standards, procedures and training, but also by raising the safety awareness of all people involved.

Raising awareness however, requires first of all, the leadership and commitment from the most senior people in the organisation. It is they who must lead the change process and they who must ensure that plans are in place, adequately resourced, and with clear channels of responsibility.

The senior managers must recognise that they have to have a passion for safety and must ensure that their beliefs are transmitted throughout their company.

In addition, senior managers and their line management must demonstrate their commitment through their own individual personal behaviour. Management must lead by example in order to have a positive influence on workers’ attitudes and behaviour to continuously improve the safety culture within the company.

Over the years many companies have introduced initiatives designed to develop their safety culture.

The challenge for the supply chain industry is to implement similar initiatives recognising, in many cases, the itinerant nature of the work force.

The most critical factor to be addressed, if real safety behavioural change is to be achieved, is to effectively involve and communicate with the work force. This will mean overcoming the fact that this work force, in the transport industry, is (a) at most times away from the work place and (b) communicated to by a planning officer rather than through supervisors.

The following sections contain guidance and best practice identified by an ECTA/EPCA/CEFIC work group.

It is highly recommended that these guidelines should be referred to either in the contract or be repeatedly referred to in bilateral discussions between the Logistics Service Provider and the chemical company.

BEST PRACTICE

1. Leadership/Visibility

(i) Senior managers need to set targets for their visibility and involvement in the safety programme. Methods involve attending meetings, discussion groups and internal auditing. The key is to show others in the organisation that safety is a high/top priority.

The senior manager has to be seen as the owner of the safety policy and has to ensure that responsibilities to achieve this are clear.

(ii) Senior managers must also demonstrate their commitment by leading investigations into serious incidents and not solely relying upon leadership from within the safety section. Participation in a small number of investigations conveys the required message.

2. Sharing the Learning

This can be done by:-

- memos
- notice boards
- safety newsletter
- posters
- drivers manual
- training
- 6 monthly meetings
- regular/short discussion group (tool box talks)

Tool box talks (30 minutes maximum) held on a regular basis are seen as the ideal way but not many transport companies are currently able to achieve this. A key to success is to find methods of achieving these two-way discussions.

3. One to One Discussions

Some hauliers carry out spot checks on a regular basis. These are normally carried out by line management checking the driver/vehicle compliance with equipment standards.

Chemical companies have also developed short one to one sessions to discuss safety issues and promote safe behaviour (See Appendix 1 for details).

The haulier spot checks should be recognised as best practice and should be extended to include these short safety discussions.

4. Take Time Out

Some companies have devised ways for employees to think about safety, in a structured way, before starting a job e.g. “Take Two and Stop”. It would be possible to devise a similar system for drivers, to be used by them for a few minutes, before starting loading or off-loading.

5. Behaviour Based Safety

Even with good procedures and an excellent management system, incident rates tend to stay the same unless workers also change behaviour. Focusing on human behaviour means looking at how people do their jobs. A suggested process for this, as developed by DOW, is shown in Appendix 2.

6. Incident Investigations/Human Error

In some areas, incidents in the supply chain, particularly at loading/off-loading, are caused by human error/inappropriate behaviour. Unfortunately most investigations do not identify cause beyond human error. Cause Tree Analysis is a technique which helps overcome this together with check lists and prompts (See Appendix 3 – Accident Investigation and Use of Cause Tree Analysis).

Cause Tree Analysis looks more deeply into reasons for human error such as stress and fatigue and requires management to take corrective action beyond mere discipline. It is recommended that training courses in this technique are identified and made available throughout the industry.

7. Near Misses

The responsible reporting of near misses or unsafe acts is seen as an essential way to raise the profile of safety.
It is important however that these near misses are followed up and the learning shared. Any incident reporting and corrective action system should include near misses/unsafe acts.

8. Responsibility

Whereas it is vital that the most senior members of an organisation are concerned with leadership, their responsibilities for safety and that of the rest of the line management, have to be clearly defined in these standards and procedures.
Safety awareness and behaviour improvement must be a critical element of these policies, standards and procedures.

9. Positive Measures

Raising the profile of safety, increasing awareness and moderating behaviour is a challenge. Ideally, organisations should be putting plans in place to achieve this and should be measuring progress.

These measures are positive measures aimed at improvement. Examples could be the number of people involved in tool box talks versus plan, the number of spot checks versus plan or the number of training days versus plan.

“What gets measured gets done”.

10. Haulier/Shipper Interface

As safety in the supply chain encompasses the haulier/shipper interface, it should be the common aim of both hauliers and shippers to meet regularly to share ideas for safety improvement and to share the learning from accidents and incidents.

LOADING/UNLOADING AREAS

LOADING/UNLOADING AREAS

All of the above sections apply not only to the haulage industry but also to the chemical companies and storage companies operating loading and off-loading facilities. It is intended to cover the entire supply chain.

Appendix

Appendix 1

One to One Discussion and Leadership through Walk the Talk .

Appendix 2

A Behaviour Based Safety Improvement Process.

Appendix 3

Incident Investigation — Use of Cause Tree Analysis.

Appendix 1

One to One Discussions and Leadership through "Walk the Talk".

1. Set a time in your diary.

2. Observe people working; a quick scan round first to identify what is going on is the best way if there are a number of people around.

3. Look for what is being done correctly and what, if anything, is not. Look out for the quick correction of behaviour when people catch sight of you.

4. Study what is going on in some detail and talk to the people involved, don't just rely on a superficial glance. Try to find out if things are satisfactory beneath the surface. The person may be using the correct equipment, but is it in satisfactory condition? – are boot soles worn down? – are goggles close enough to the face? – is it possible to see through the lens? – are the tools in good condition? Accidents are often avoided because all details are up to standard – you need to look at details.

5. Make a point of finding things that are being done correctly – (not just incorrectly) and recognise these. People often feel threatened when observed and approached, but the audit achieves nothing if sub-standard behaviours are not corrected. The best approach is a chat around the subject. Explain that your concern is for their welfare and safety. Discuss any unsafe act with the person and ask them if they see any risk in what they are doing – ask them where they see the real risks in the job – you may be surprised at what you are told!

6. Even though the chat is reasonably informal, even friendly in nature, still make it quite clear that sub-standard and unsafe behaviour cannot be tolerated.

7. Once the person has realised that they are taking a risk, try to find out why. What is the root cause of their unsafe act, e.g.:-

   (a) Do they just not understand the risk?
   (Is the training adequate?)

   (b) Is the official safe system impractical?
   (Whose job is that to put right?)

   (c) Is safety equipment readily available?
   (Who is going to correct that?)

   (d) Is there too much time pressure?
   (Who dictates that?)

8. Discuss possible solutions to whatever the problem is. Most of the time an immediate solution will be possible, particularly where the problem is one of motivation or understanding, but others may require further investigation or follow-up action.

Appendix 2

A Behaviour Based Safety Improvement Process

1. Review the incident data at the Transport Service Company for a period of time (at least a year). It is advantageous to involve employees in this process as much as possible. Group the incidents into categories and prioritise them.
2. Select the top categories for observations, an example being that Motor Vehicle Accidents may be top priority.
3. Focus on incident types within a category – rear end collisions may be the first in Motor Vehicle Accidents.
4. Establish a work-group to identify the major causes of these incident types. e.g. rear end collisions.
5. As the programme progresses consider other categories including loading and un-loading and then the causes of these incidents.
6. Identify the behaviours which cause these incidents, or which can prevent them.
7. Employees should be involved in the process and asked to act as observers and to report and record deficient behaviour through observations.
8. Collate the results of the observations and report the results to all the relevant employees.
9. Report and measure Monthly Safety Performance showing impact of safety awareness activities.
10. Set realistic goals for reduction of the various incident types.

Appendix 3 - Part 1

Incident Investigation – Use of Cause Tree Analysis

1. The purpose of cause tree analysis is to identify basis causes or root causes.

2. The starting point is a description of the incident. For example this could be – “Operator got acid in eye” or “Driver twisted ankle”.

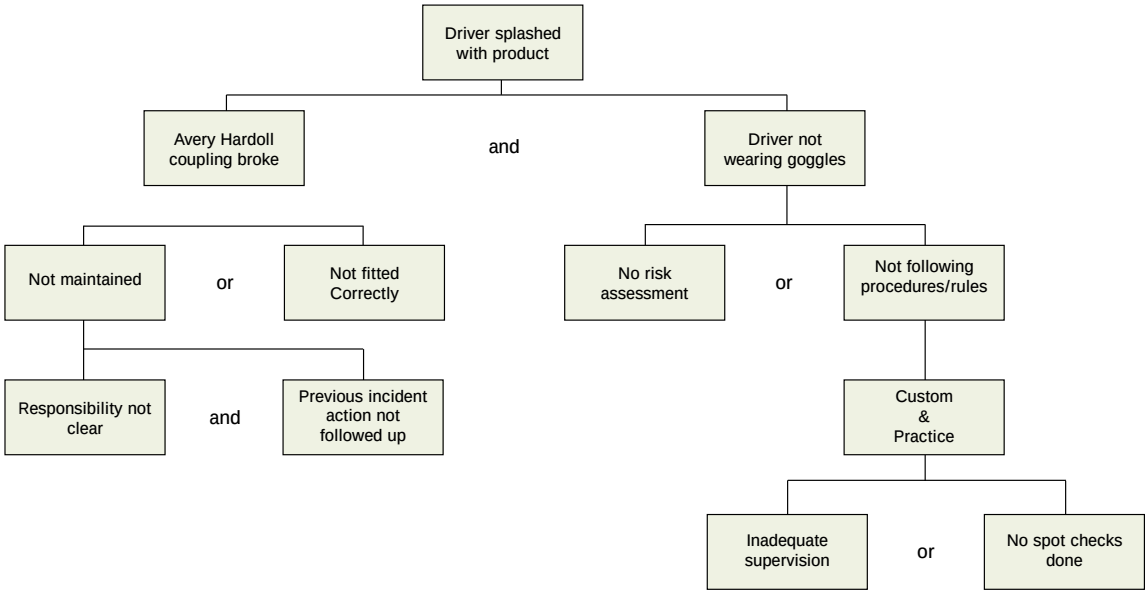
3. The next step is to ask the question “Why did this happen?”. There may be more than one answer to this. For example “Not wearing goggles” and “There was a leak of acid”.

4. A start can now be made in constructing the cause tree. There could now be more than one leg as in 3 above.

5. Keep asking the question “Why did this happen ?”.

6. Continue constructing the cause tree and asking the question “Why ?”. Continue until the basic causes have been revealed. The key areas to consider are shown in Appendix 3, part 2.

7. An example of a cause tree is shown below.



Appendix 3 - Part 2

Incident Investigation – Use of Cause Tree Analysis.

Was there a clear PROCEDURE or INSTRUCTION describing what had to be done?

Were the right people adequately TRAINED?

Was the procedure or instruction being COMPLIED WITH?

What aspects of PERSONAL SAFETY AWARENESS, for which individuals are ACCOUNTABLE, were involved?

Was the WORKING ENVIRONMENT adequate?

What issues of EQUIPMENT FAILURE were involved?

PROCEDURES	*TRAINING*	*COMPLIANCE*	*BEHAVIOUR*	*EQUIPMENT*
• *Relevant?*	• *Induction*	• *Unsafe act*	• *Communication*	• *Design*
• *Exist/available/clear?*	. *General*	• *Short cut*	• *Auditing/SUSAs*	• *Maintenance*
• *Responsibilities*	. *Plant*	• *Mistaken priority*	• *Blatant disregard*	• *Inspection*
• *Risk assessment*	. *Product*	• *Lack of knowledge*	• *Horseplay*	• *Modification*
• *Routine task*	• *Refresher*	• *Auditing*	• *Clear understanding*	• *Wear & tear*
• *Unfamiliar task*	• *Adequacy*	• *Spot checks*	• *Complexity*	• *Abuse/misuse*
• *Custom & practice*	• *Validation*	• *SUSAs*	• *Confusion*	• *Housekeeping*
• *COSSH*	• *Supervision*		• *Stress*	• *Suitability*
• *PPE required*	• *Communication*		. *Work*	• *Correct tool for job*
• *Manual handling*	• *Information*		. *Home*	• *Ergonomics*
• *Security*	. *Updating*		• *Mental capacity*	• *Noise*
	. *Passed on*		• *Personal attitude/ behaviour*	• *Lighting*
	. *Job tips*			• *Heating*
	• *Warning signs*		• *Fatigue*	• *Weather conditions*

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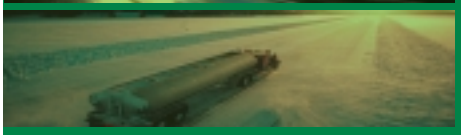

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