

# *International Mining & Minerals Safety & Health Conference 2006*



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*Creating a "Mature Reporting Culture"*

# Location



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# Peak Downs Mine



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# *Presentation Logic*



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- *Situation at Peak Downs Operation*
- *Tactics used to create a mature reporting culture*
- *Actions Strategies*
- *Results of the change*

# *Situation evolving at Peak Downs Operation*

- *A Series of High Potentials events – (the looming possibility of a fatality).*
- *History of being reactive when a proactive approach was required.*



# *Methodology used*



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- *Applying the lessons from events such as Moura, Longford and Piper Alpha. (all had a series of minor reportable incidents leading up to the disasters).*
- *Align the theories of Reason, Weick, Sutcliffe and Hopkins into working model that embraces collective mindful approach.*
- *Building blocks of the "Peak Downs Model" breaking down the change into a series of influencing elements that effect the behaviour and attitudes of the workforce.*

# *Strategies & Actions to create the maturity*



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- *Identifying Best Practice  
("Reporting Culture")*
- *Just Culture*
- *Timely Feedback*
- *Consultative Process*
- *Informed Workforce*
- *Recognition*
- *Reporting System  
Infrastructure*

Start.exe

## Identifying Best Practice

- *“Culture, especially of an organization, is increasingly identified as a key factor in the success or failure of enterprises”. (Waring, A)*
- *Peak Downs work environment prior to 2004*
- *Key points identified as best practice*

- *Hopkins has identified that "if blame is the routine response to error, then reports will not be forthcoming. If on the other hand blame is reserved for behavior involving defiance, reckless, or malice, reporting in general will not be discouraged. What is required is not so much a no-blame culture as a just culture" (Hopkins, Andrew. Safety, Culture and Risk, 2005, p12, CCH)*

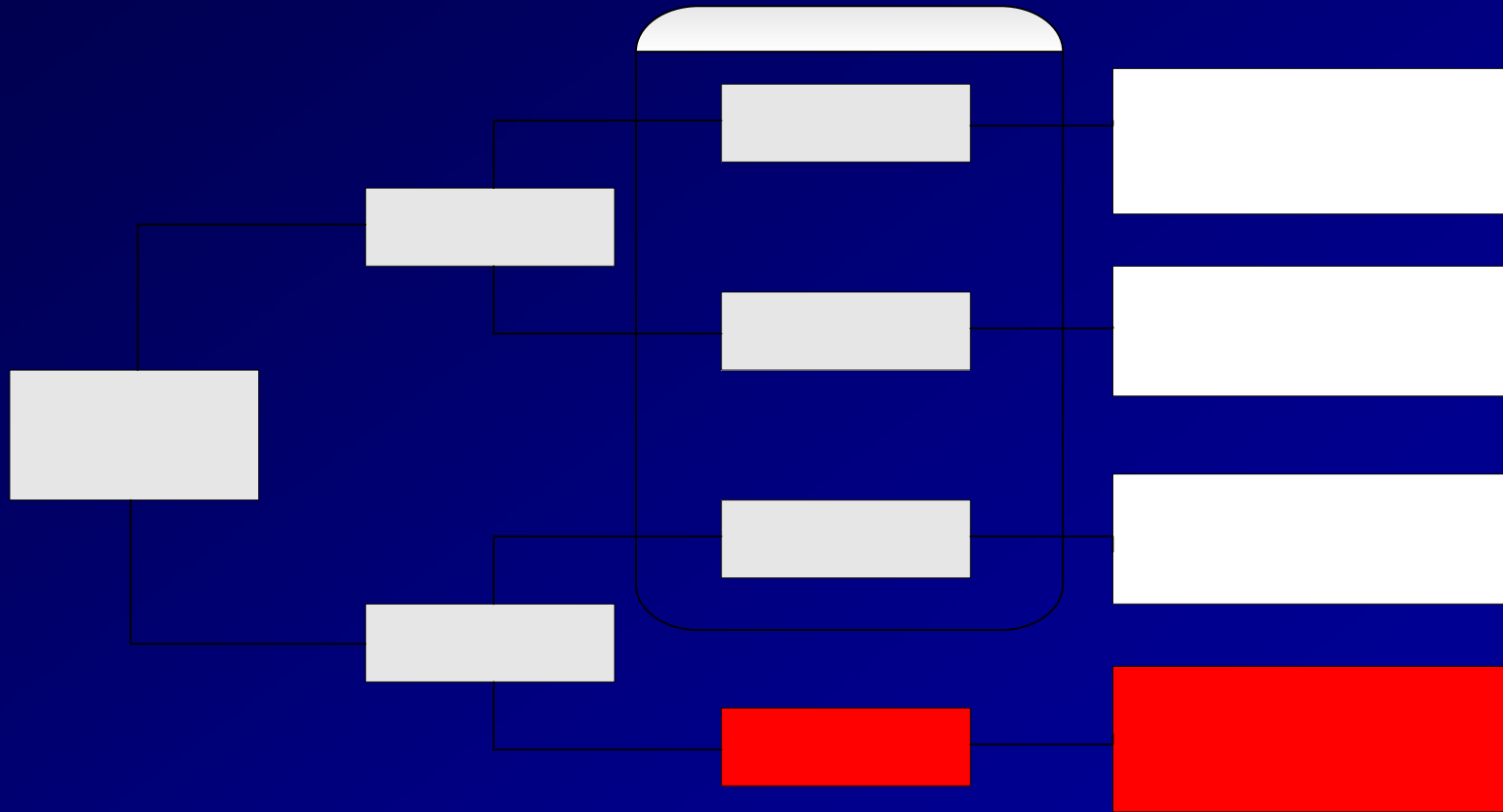
Start.exe

*Therefore the initial response of a reported incident has to be open minded and consider the influence of human error.*

# *Reason's Human Error Model*



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# Timely Feedback



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- *Ongoing feedback given on the status of report findings*
- *Near Miss reports are reviewed fortnightly*
- *One on one feedback given to the person*
- *Reports followed up to gauge the performance of the changes*

# Consultative Process



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- *Individual areas to make decisions on issues*
- *Implement change away from common site and industry practice*
- *Sub committee empowered to give direction to the Central HSE Committee*
- *Creating ownership of the systems of work*

- *“An informed culture is preoccupied with the possibility of failure and works continuously to become more resilient to its operational hazards” (Reason, J. Building a Safe Culture p3, 2005)*
- *Collectively reporting errors and near misses at all levels.*
- *Collectively Mindful of change within a*
  - *Process*
  - *Engineering*
  - *Strategies i.e. (Award programs)*

# Recognition & Sustainability



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- *Creating the understanding*
- *Recognising and valuing each report*
- *Sustainability of the reporting process*
- *Continuous improvement*

# Reporting System Infrastructure



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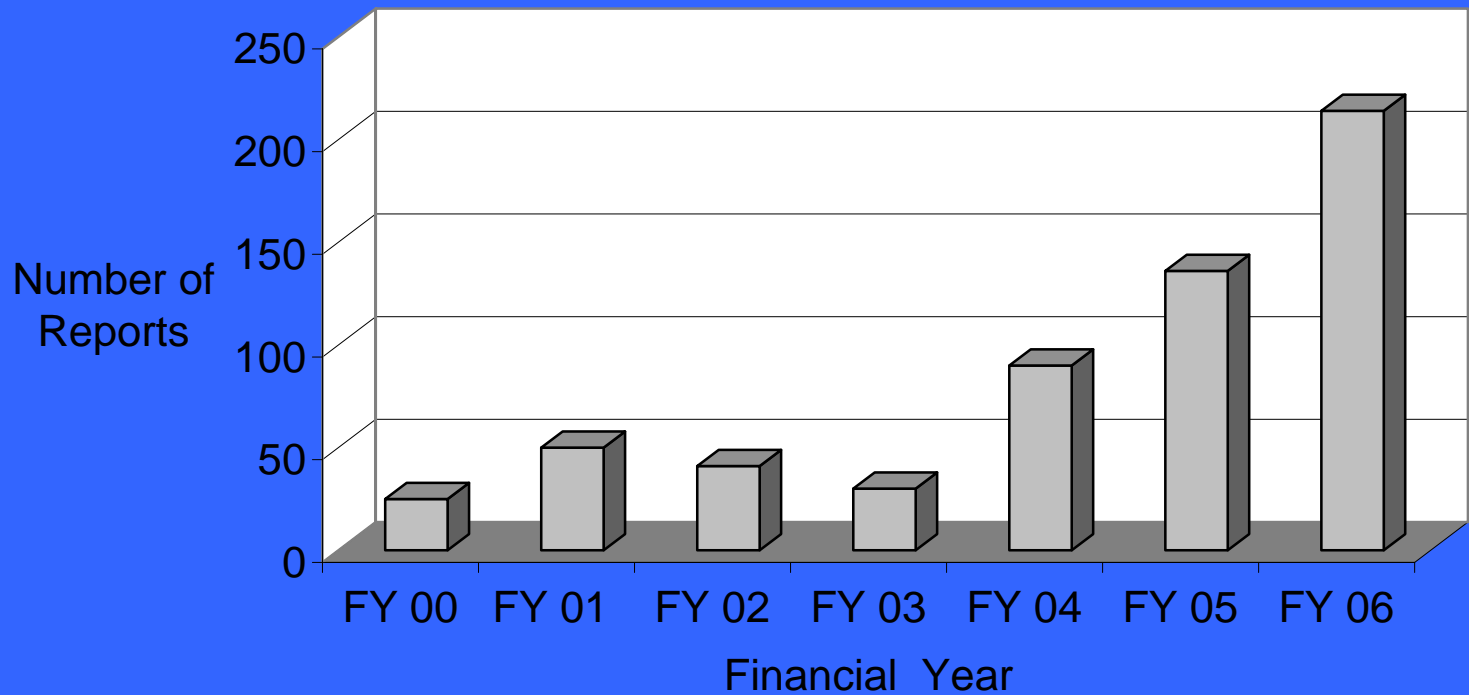
- *Reason states, for any safety information system depends crucially on the willing participation of the workforce, the people in direct contact with hazards. (Reason, James. 97)*
- *Capable of recording and tracking reported events.*

# Reporting Journey

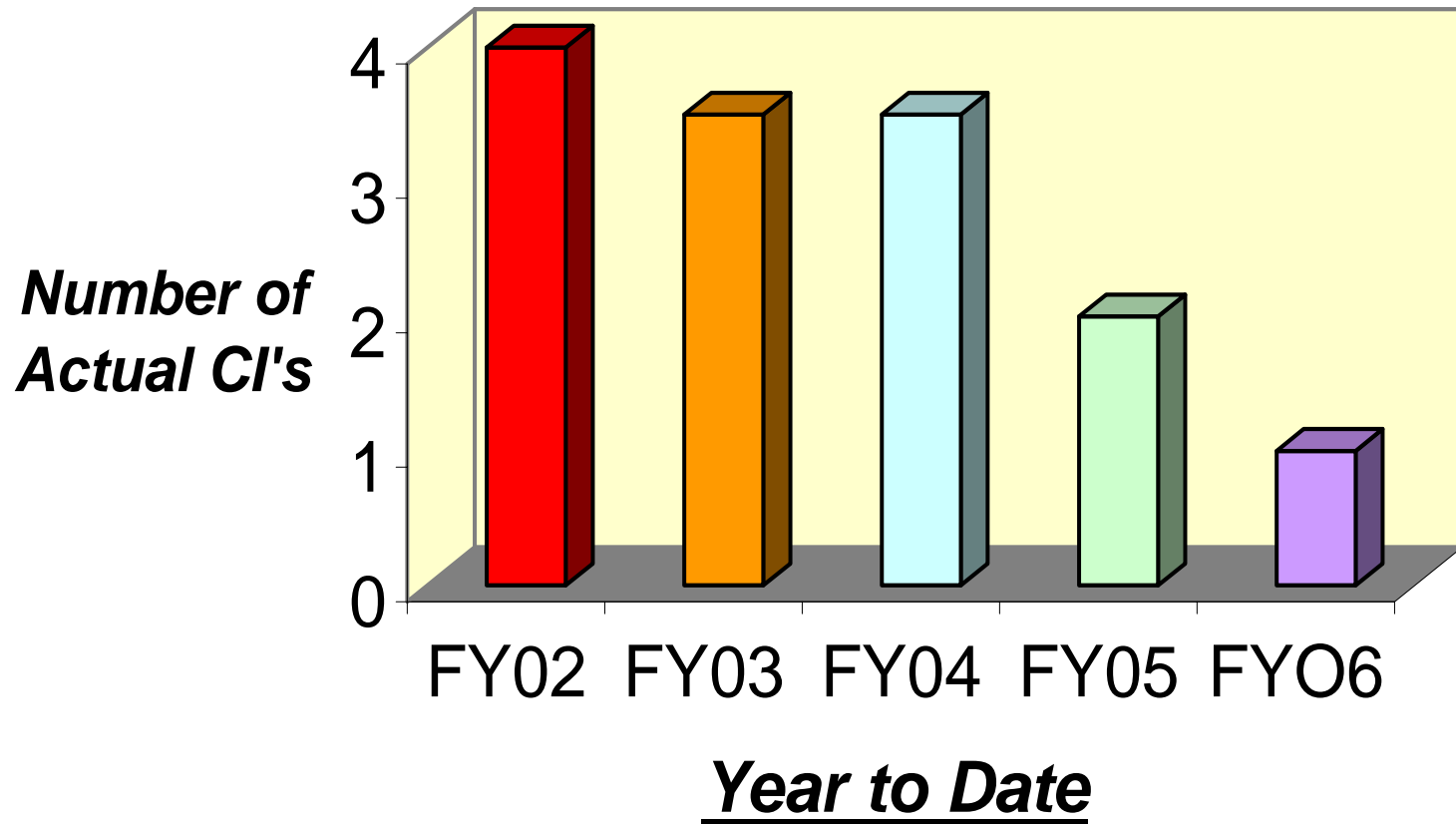


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## Near Miss/ Hazard Reporting



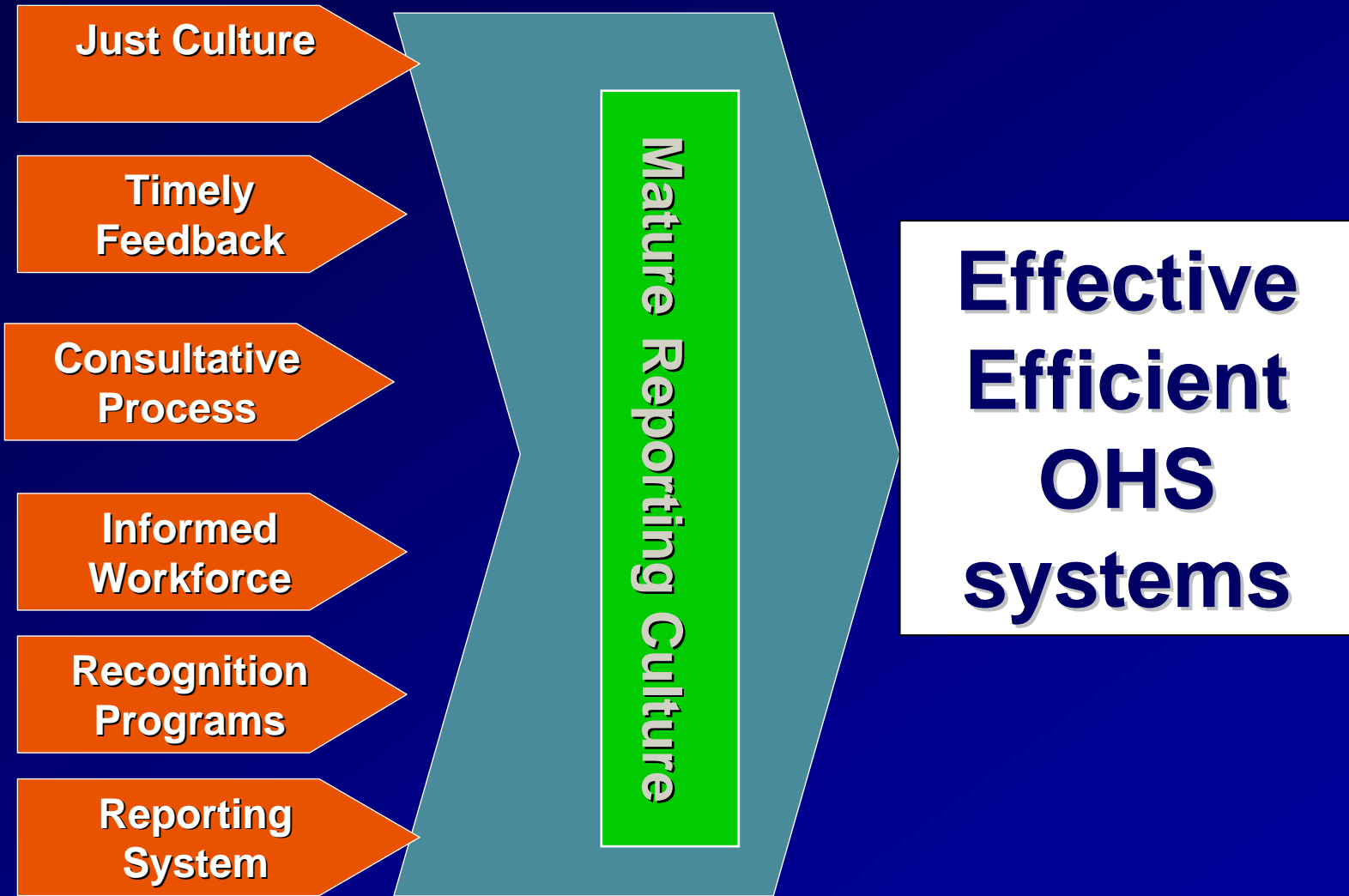
## History of Classified Injuries at Peak Downs



# *Mature Reporting Culture Model*



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# *Acknowledgements*



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- *BHP Billiton BMA Peak Downs*
- *Peak Downs Mine Near Miss Sub-Committee*
- *Hayden Cater*
- *Work Shape*
- *University of Ballarat*

# *Winning the World Cup (Billy)*



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