

How to deliver an effective corporate strategy

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Rio Tinto - Where we were - 1998

- ✘ 10-20 Fatalities a year over previous decade
- ✘ Lassing underground mining disaster (10 fatalities in small mine)
- ✘ Senior leaders not well informed
- ✘ Leadership not engaged in safety effort
- ✘ No clear strategy or plan on how to address safety



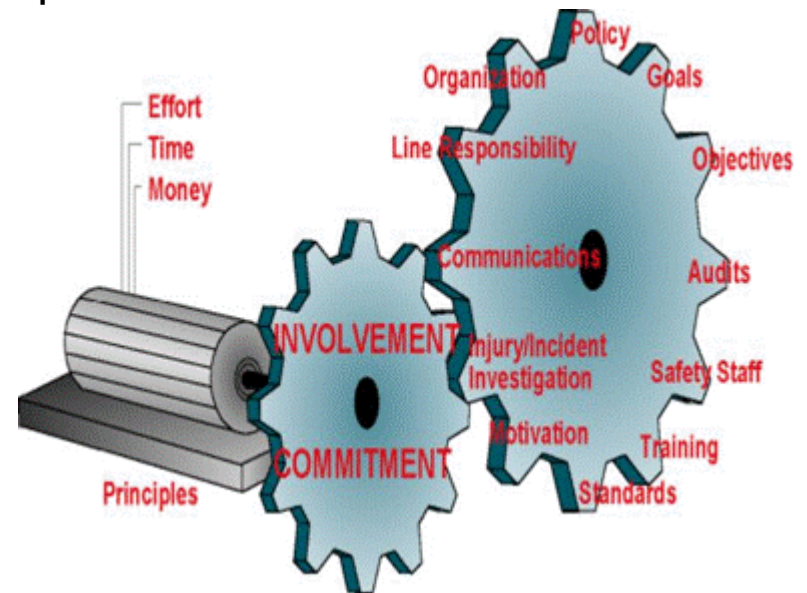
Where we are now - 2006

- ✓ Less than 2 fatalities per annum – still not there
- ✓ Leaders actively leading strategy
- ✓ Significant reductions in key injury statistics
- ✓ Pockets of excellence across continents – more to do
- ✓ Significant issues systematically dealt with as they 'surface'
- ✓ Greater consistency in leadership being achieved



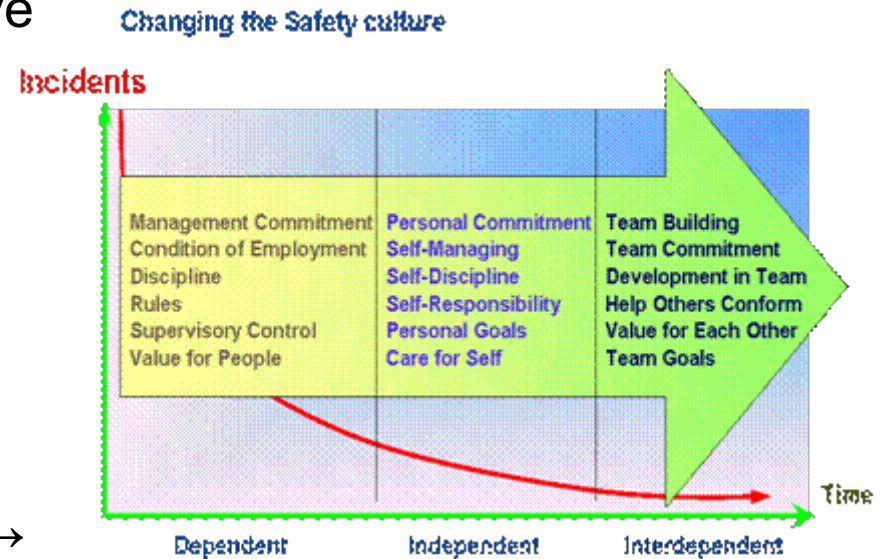
How did we get there? - What did we do?

- Leadership - visible commitment backed up with resources →
- Vision and Principles clearly articulated
- Understanding/managing the numbers
- Corporate strategy and plan (2000 →)
- Safety standards and audits (2000 →)
- DuPont Reviews (1999, 2002 and 2004)



How did we get there? - What did we do?

- Safety Adviser to the Chief Executive (2000 →)
- Safety Leadership Panel (2003 →)
- Six Short Term Priorities (2004 →)
- Collaborative Fora /Focus Groups →
- Best Practice Transfer / Networking →





Six priority or focus areas

1. Strengthen safety leadership
2. Hold individuals openly accountable for results
3. Improve incident investigation
4. Identify and manage all critical and high level risks
5. Improve Safety Interactions
6. Full compliance with our minimum safety standards.



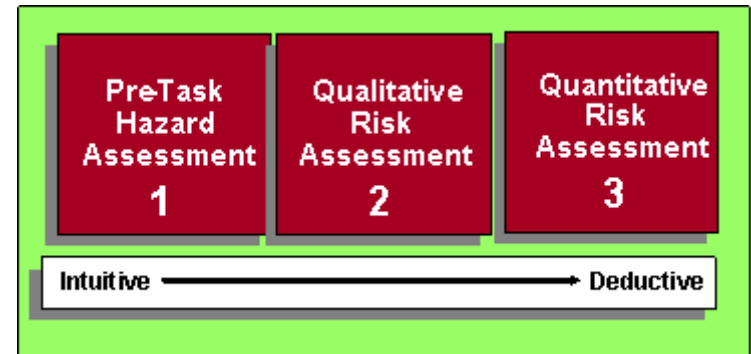
What could we have improved upon?

- Safety Leadership Development – more emphasis on ‘learn by doing’.
- Balance between improving safety and improving reporting
- A more balanced use of lagging indicators and use of leading indicators
- Sharing of lessons learnt and less tolerance towards ‘repeats’
- Communications



What could we have improved upon?

- Our understanding of risk and potential consequence/severity
- Support for high risk operations and underperformers
- Safety Interactions – ‘roll out’ and numbers vs. quality
- Consistent support for front line management
- Engagement with, and contribution from, front line employees





Results of Safety Culture Diagnostic Survey (2006)

	SUBJECTIVE	OBJECTIVE
INDIVIDUAL	<p><u>INTENTION</u></p> <p>VALUES ATTITUDE COMMITMENT RESPONSIBILITY INTENTION EXPERIENCE</p>	<p><u>BEHAVIOUR</u></p> <p>PLANS ACTIONS DECISIONS PERFORMANCE ACCURACY</p>
GROUP	<p><u>CULTURE</u></p> <p>SHARED VALUES ETHICS MORALE MYTHS AND LEGENDS JUSTICE FAIRNESS COVENANTS</p>	<p><u>SYSTEMS</u></p> <p>ORGANISATIONAL STRUCTURES WORK PROCESSES POLICY AND PROCEDURES SHARED MEASURES ECONOMICS CONTRACTS</p>

(From a model created by Ken Wilber)

Findings:

- ✓ Significant improvements in safety performance
- ✓ Well-established dependent-type safety culture. Pockets of interdependency at a number of sites
- ✓ Leadership “commitment” to goal of “zero injuries” well communicated
- ✓ Solid foundation of well-established safety systems



Results of Safety Culture Diagnostic Survey (2006)

Findings (continued):

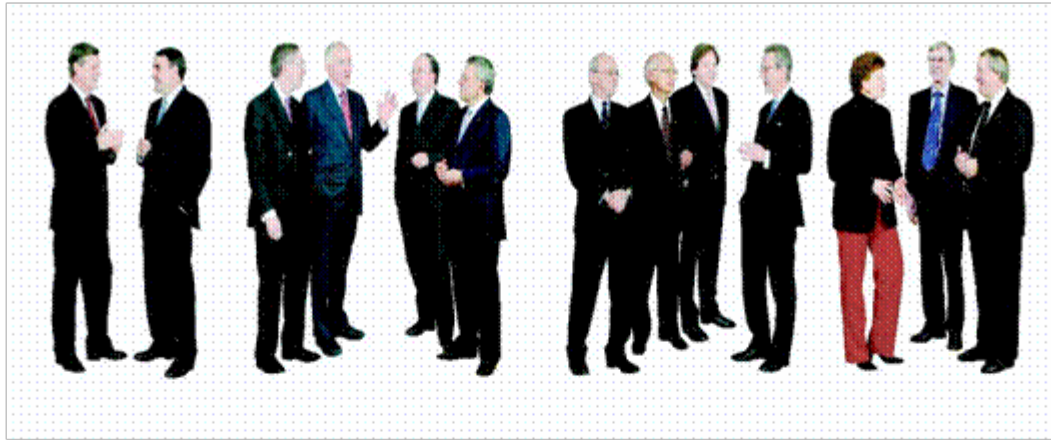
- × Insufficient focus on active caring and a belief in an injury-free work environment.
- × Safety is often seen as a business imperative rather than a value.
- × Focus on systems/numbers has driven a culture of compliance and not desired behaviours
- × Some employees still willing to take risks when production pressure is on or when no one is looking
- × Significant underreporting of incidents/near misses – no value in reporting, fear of reprisals, etc.



Where do we want to be? 2008 and beyond

- By 2008 to have zero fatalities and be the best in any industry
- Interdependent or team culture, ie. an improving culture
- An injury free workplace
- A healthy, happy and prosperous workforce





**Injury and illness free
That's where we want to be!**

