Risk normalisation

2018 April release
Agenda

• Review of the falling objects theme
• ‘Why’ the risk normalisation theme
• Concept of risk normalisation and the objectives of the theme
• Introduce the theme design, framework & materials available
• Timeframes and actions
• Questions
Falling objects theme – our response

Was the short peak related to the time of year the theme was released?

How can we lengthen the impact of the PFI stop?

Our initial response was to increase the focus, more verifications.

The peak was short lived.

Finding prevention and mitigation control opportunities.
Falling objects theme

Before PFI stop

- 1 in 6 PFIs related to a falling object

- Nearly half our falling object PFIs related to mechanical integrity

- Falling objects had the highest percentage of non-compliance of any risk type

- Falling object PFIs are occurring in every region in every product group

After PFI stop

- 1 in 5 PFIs related to a falling object

- Less than 1/3 of our falling object PFIs related to mechanical integrity (same number for structural integrity)

- Falling objects is the third highest percentage of non-compliance of any risk type (excluding underground risks)

- Falling object PFIs are occurring in most product groups
Why we decided on the risk normalisation theme

• Common thread from recent fatality, PFI and permanent disabling injury investigations
• Previous learning critical lessons prescribed the hazard, whereas this one allows sites / teams to determine the critical risk most relevant to them
• Aligned with human performance principles
• Builds a common language & concept across the Group
What is risk normalisation?

Risk normalisation:
• is a psychological process;
• is a natural human reaction which happens to everyone;
• happens when we are very familiar with something;
• results in us reducing our sense of unease with a risk;
• may lead to a drift in the way we do things over time; and
• leaves clues for us when it is happening.

What is it?
When does it happen?
What is the result?
How can I influence the outcome?
Relationship between time and risk normalisation
(the level of risk does not change but our perception of the risk reduces over time)
Risk normalisation Fatality / PFI stop - design

**Introduction & relevance**
- Leader makes it relevant to the team by using their own words to describe a local example

**Theory (video)**
- What is it
- Why does it happen
- What is the result
- Relatable examples
- How can I influence the outcome
- (video provided)

**Incident example (video)**
Choose 1 of 3
- Kennecott
- Bell Bay
- Sorel

**Reflection**
- Look through fresh eyes (if you brought a family member to work)
- Risk normalisation scenario's
- Identify clues

**Action**
- Site to cascade up actions
- Entered into system
- Encourage sharing of good practice via Yammer
Bell Bay – Serious burns from collision between forklift and bath pot

Date: 25th May 2017  Actual Consequence: Serious  Injury: LTI / PDI

**Brief Description**

Bath Transfer work was being conducted in the potlines at Bell Bay. A process controller was driving a forklift carrying a launder, the launder struck a bath pot that was suspended on the hook of a general purpose crane. The crucible contained over 2 tonnes of molten bath material, around 400 kilograms of the material was spilled from the crucible, some of the bath material contacted the forklift driver. This resulted in extensive burns to the neck, shoulders, back, chest, arms, hands and legs.

**Summary of findings**

- There was a reliance on a social process - non-verbal communication.
- Molten material controls were not adopted as contact was not considered possible in this area.
- The design of the bath crucible meant the lid had to be off to allow bath to be discharged.
Two incidents, technically unrelated:

- South CO Gas Room Explosion (30/03/17)
- An explosion in a furnace due to the presence of water (02/02/18)

Lessons for others:

- Maintain operational knowledge
- Ensure critical systems have reliable and effective warning processes
- Risk normalisation
Reflection questions

“If a new starter joined our team tomorrow, what might they see that you have stopped seeing”?

1. What are our normalised risks? What have we stopped seeing?

2. How can we get better at noticing the clues?
Risk normalisation materials

Element > Our safety > Learning critical lessons > Risk normalisation

- Fatality / PFI stop contents
- Introduction to risk normalisation (video)
- Three incident lesson videos (site / team to choose 1)
- Reflection questions
- Actions poster
- How to conduct a fatality / PFI stop
- Risk normalisation facilitator steps
- Facilitator guide
- GM / Manager guide
- Guidance note
- Additional resources
Roles in this process

Leaders (MD / GM / Managers)
- Determine the roll-out strategy
- Cascade the roll-out to facilitators
- Make it relevant and personal
- Set expectations about what will be achieved
- Champion the process

Frontline employees and contractors
- Facilitate learning conversations with each of the crews
- Identify a few relevant actions and cascade
  - Action what you can
  - Escalate what you need help with
- Supervisors to support and observe

Learning champion (HS Managers)
- Make it relevant to the site
- Guide leaders in the process
- Support the:
  - roll-out
  - consolidation of actions
  - logistics

Facilitator (Superintendents)
Risk normalisation, the challenge…

How do we see the things we have stopped seeing?

Effective delivery, the challenge…

Natural human reaction
Happens to everyone
We need open and honest reflection
Reinforce, this is not about blame
Roll out timeframes & actions

Risk normalisation theme

- Release April 2018
- Sites to hold facilitated discussions with teams by end June
- Top few actions per site to be in system by end July
- Please share best practice examples on Yammer safety share page
- Tracking and reporting
- Consider facilitator support
  - Is a process and delivery refresher required?
  - Who can help with this?