



# Organisational Reliability

Dr Sean Brady  
Brady Heywood

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# Review

of all fatal accidents in  
Queensland mines and quarries  
from 2000 to 2019

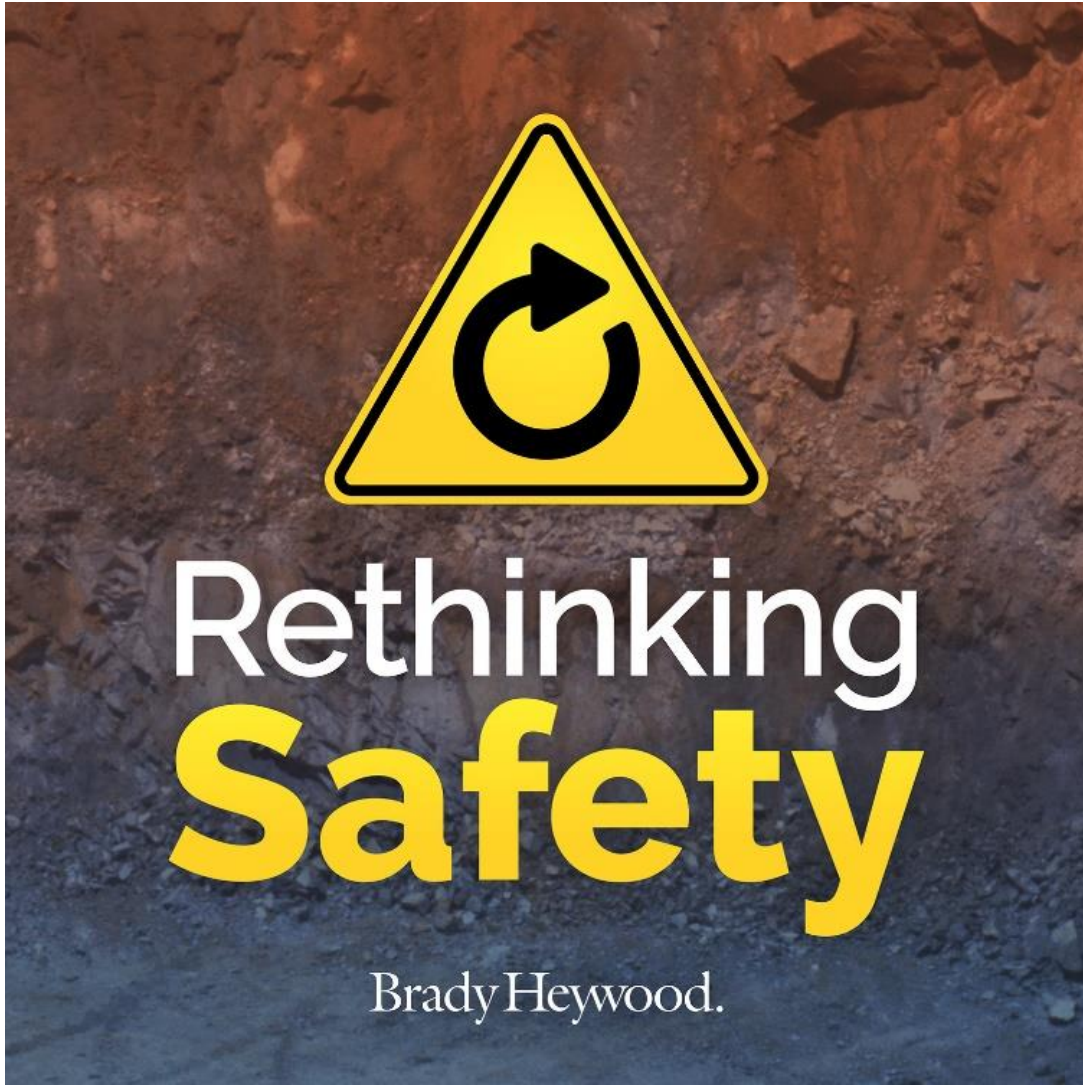
By

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for the Department of Natural Resources, Mines and Energy

December 2019

[www.bradyheywood.com.au/publications/](http://www.bradyheywood.com.au/publications/)



# Questions...

- What do you believe causes fatalities?
- What is the role of human error in fatalities?

# Queensland Government wraps up crisis talks with mining industry after sixth death

By [Allyson Horn](#)

Posted Mon 8 Jul 2019 at 12:35pm, updated Tue 9 Jul 2019 at 6:28am

# 47 Fatalities.

35,000 Incidents.

1,635,566,224 Hrs.



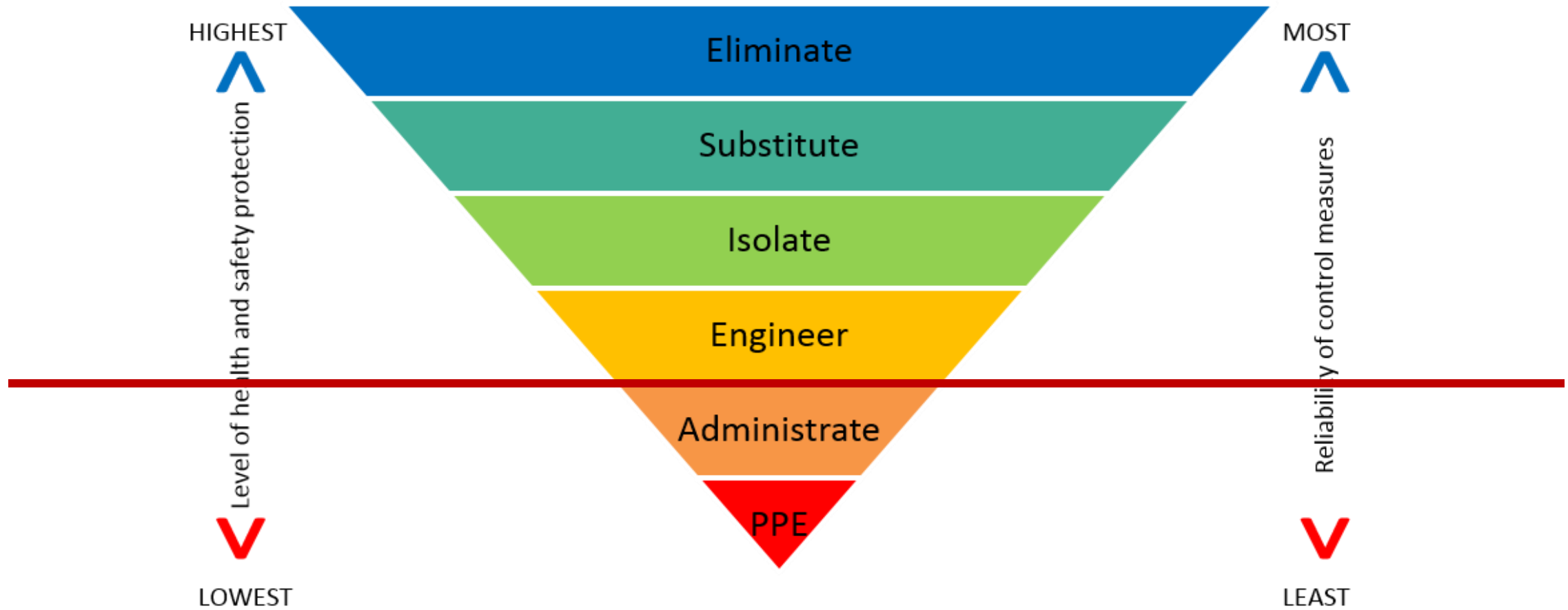
# Key Findings.

# Serious Accidents.










## Absent or Failed Controls found in Serious Accidents for All Mines

-  Hazard Not Identified - No Control
-  Hazard Identified - No Control
-  Hazard Identified - Control Ineffective
-  Hazard Identified - Control Bypassed
-  Hazard Identified - Control Unenforced

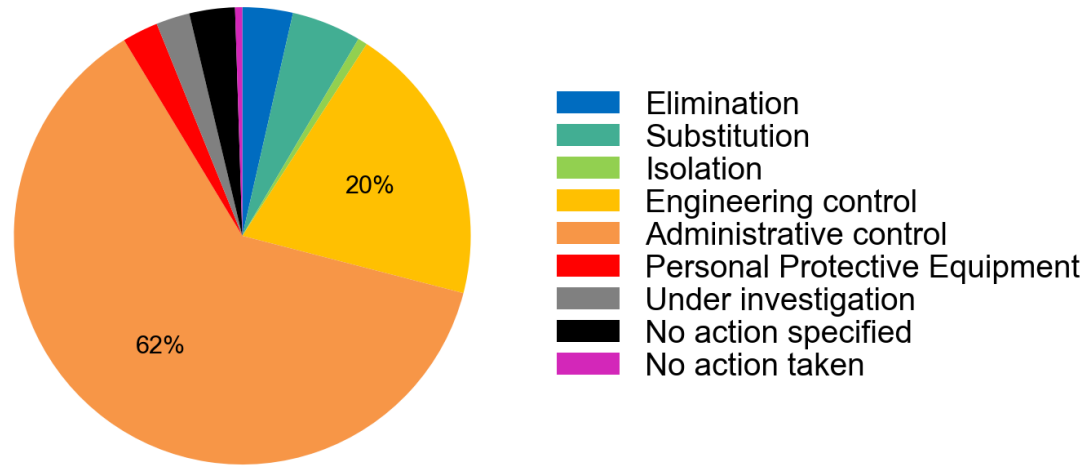
# Hierarchy of Controls.



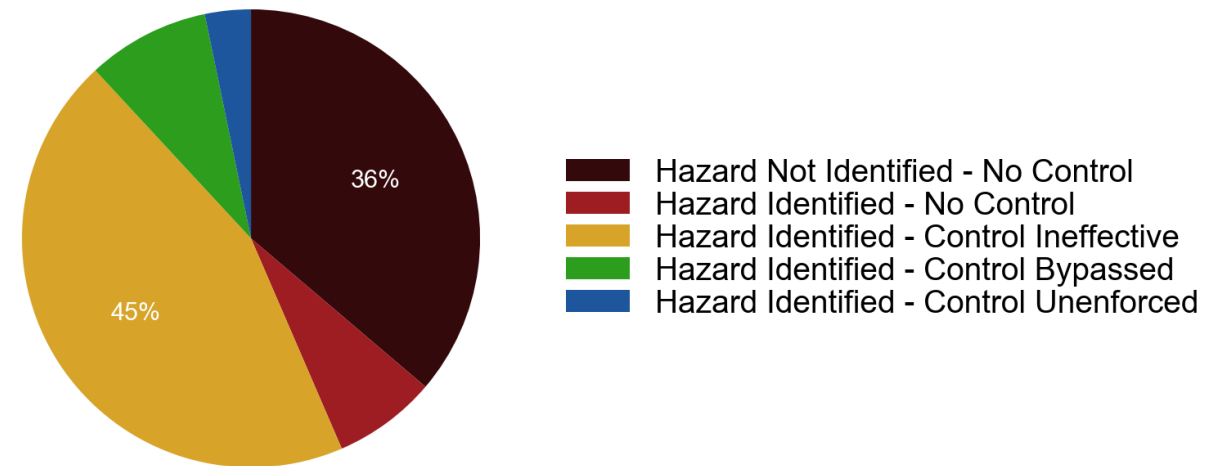
## Highest Level of Corrective Action Applied after Serious Accidents for All Mines

-  Elimination
-  Substitution
-  Isolation
-  Engineering control
-  Administrative control
-  Personal Protective Equipment
-  Under investigation
-  No action specified
-  No action taken

Highest Level of Corrective Action Applied after Serious Accidents for All Mines



Absent or Failed Controls found in Serious Accidents for All Mines





# Fatalities.



# Physical causes.

- 15 Vehicle accidents
- 12 Machinery (entanglement, crushing)
- 10 Strata failures
- 4 Falls from height
- 4 Tyre failures
- 1 Fire
- 1 Irrespirable atmosphere

Physical

Individual

Supervision

Organisational

Worker receives fatal injuries after he is thrown from, and pinned under, the bus

# Role of Factors in Fatalities.

- Lack of specific training (17)
- Inadequate training (a further 9)
- Supervision (25 of 32)
- Ineffective Controls
  
- Human error

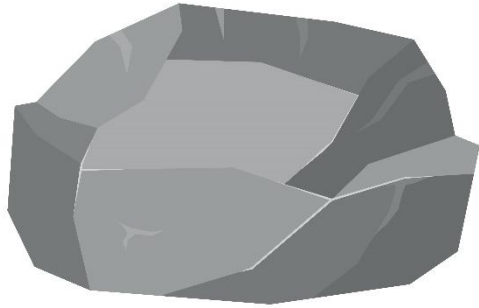
# The Fatalities.

- The causes of fatalities are typically a combination of banal, everyday, straightforward factors, such as a failure of controls, a lack of training, and/or absent or inadequate supervision.

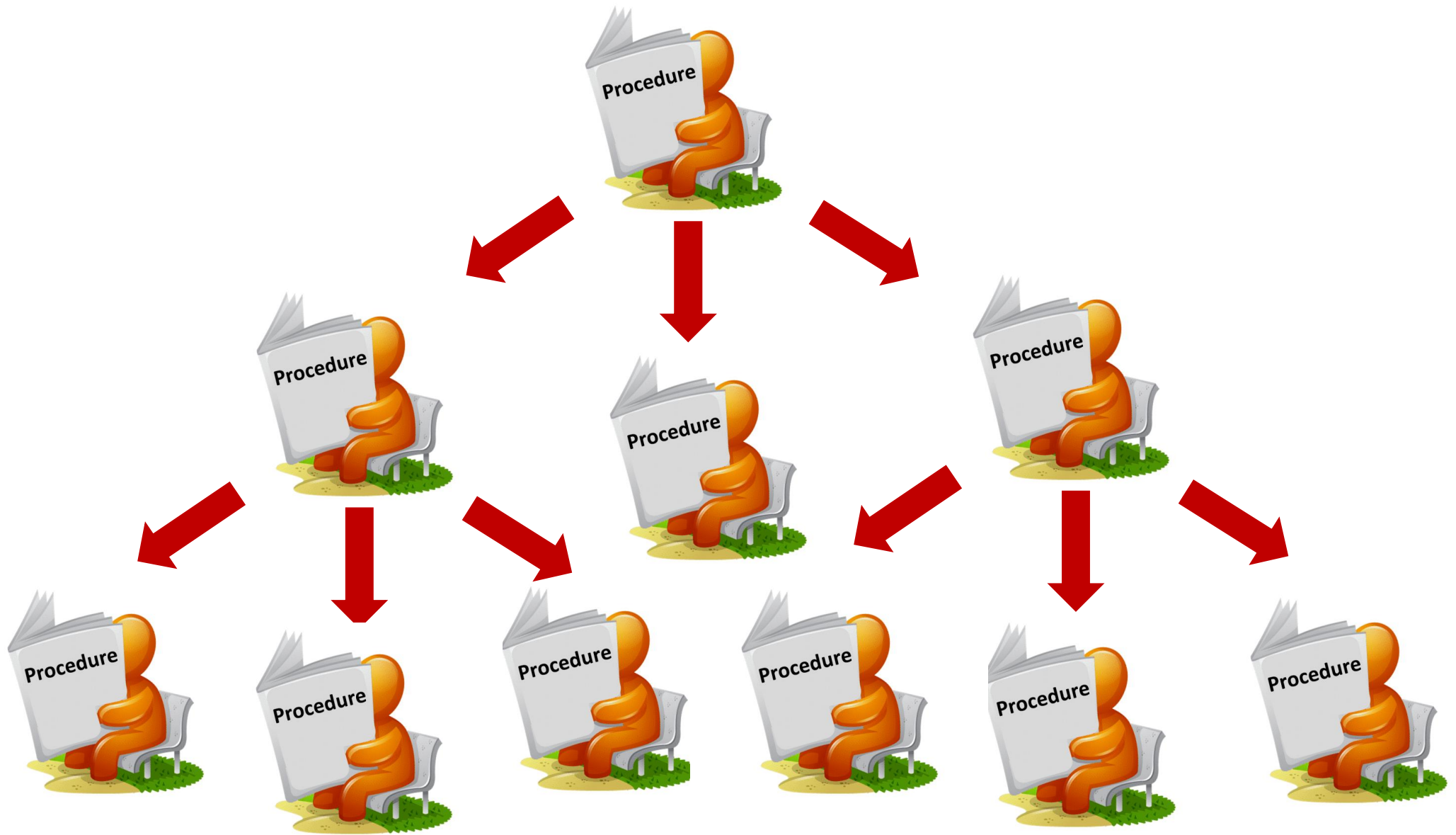
# High Reliability Organisations.

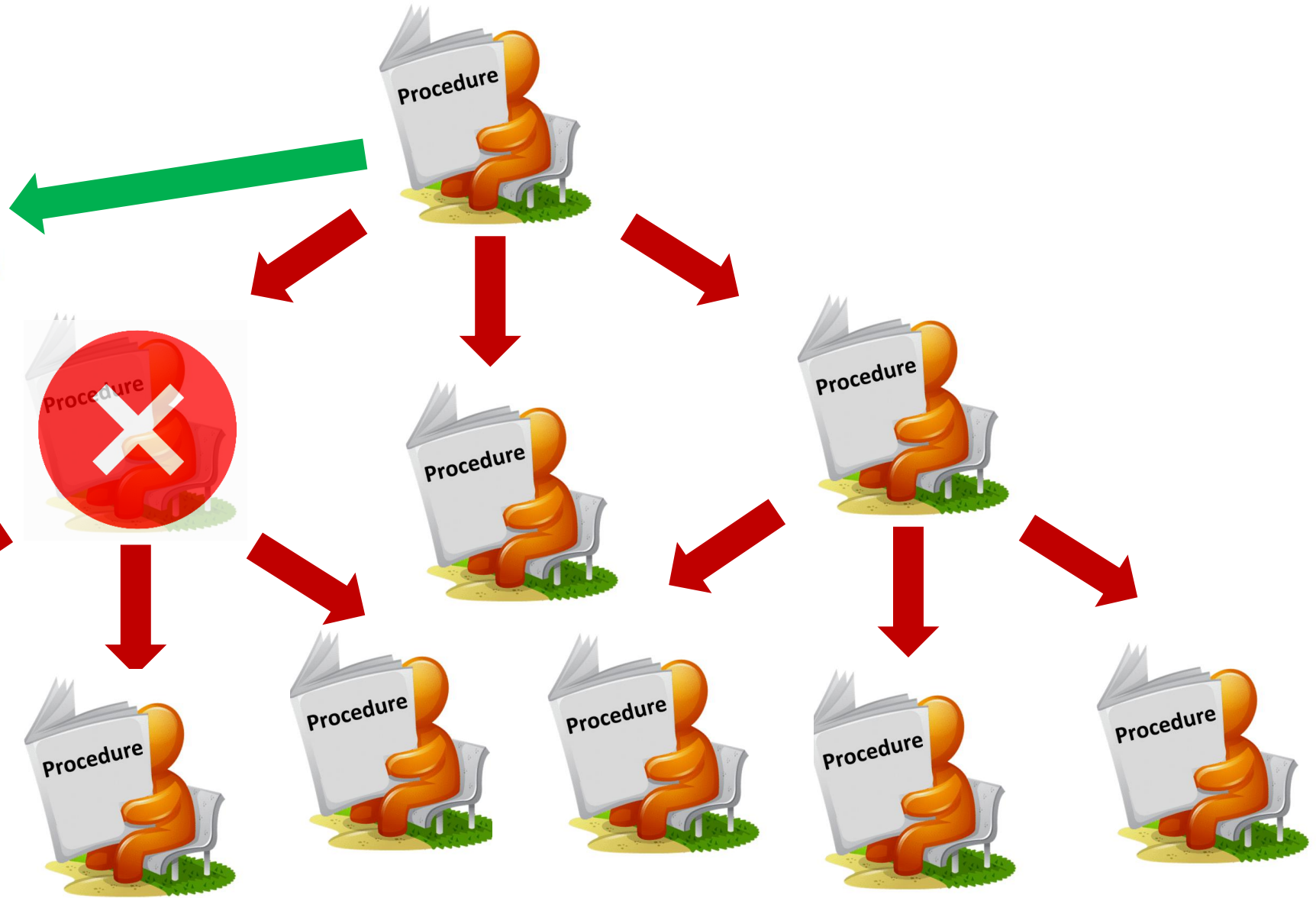


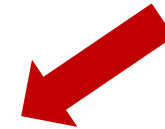
# Drift Into Failure.





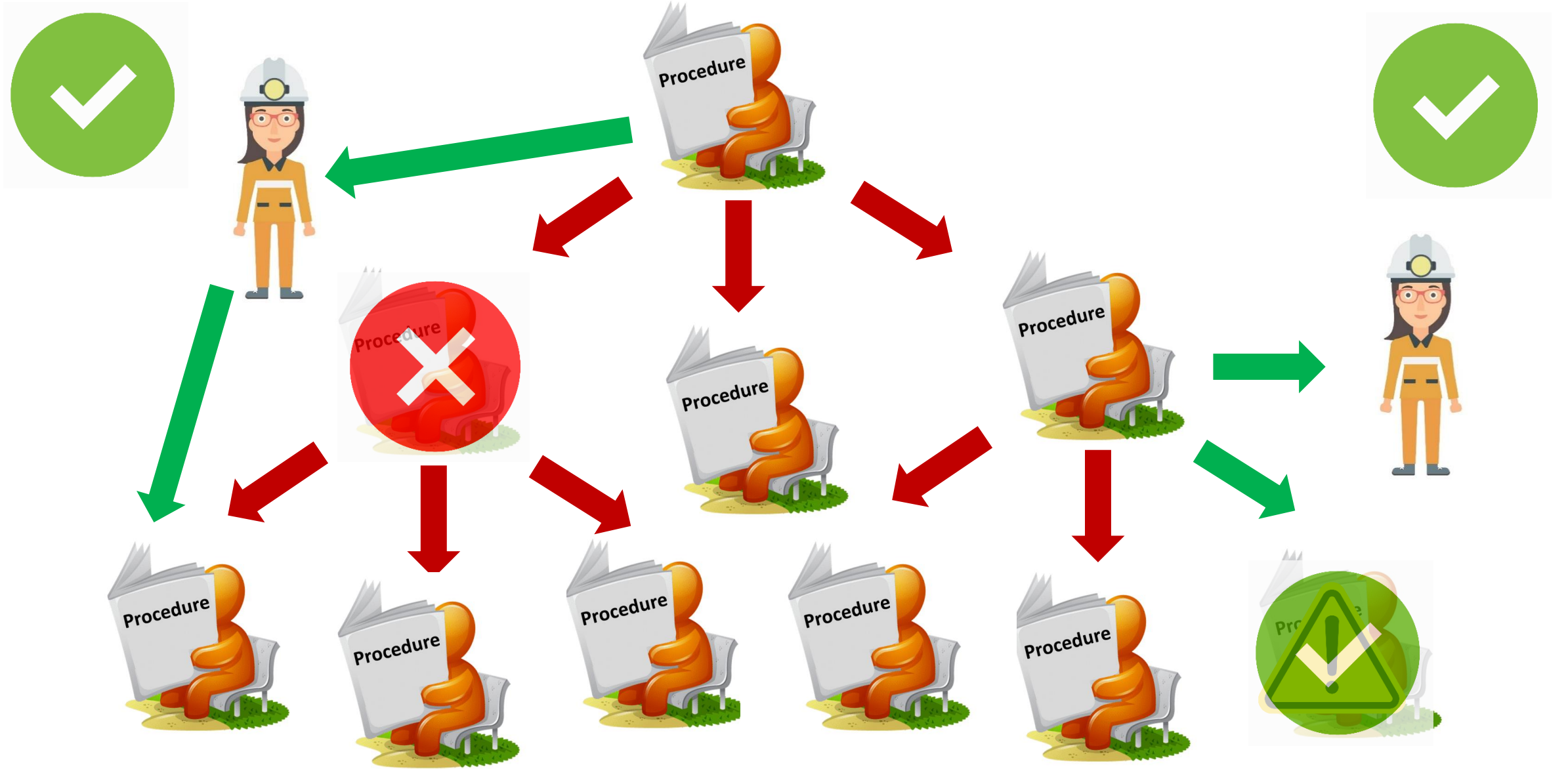


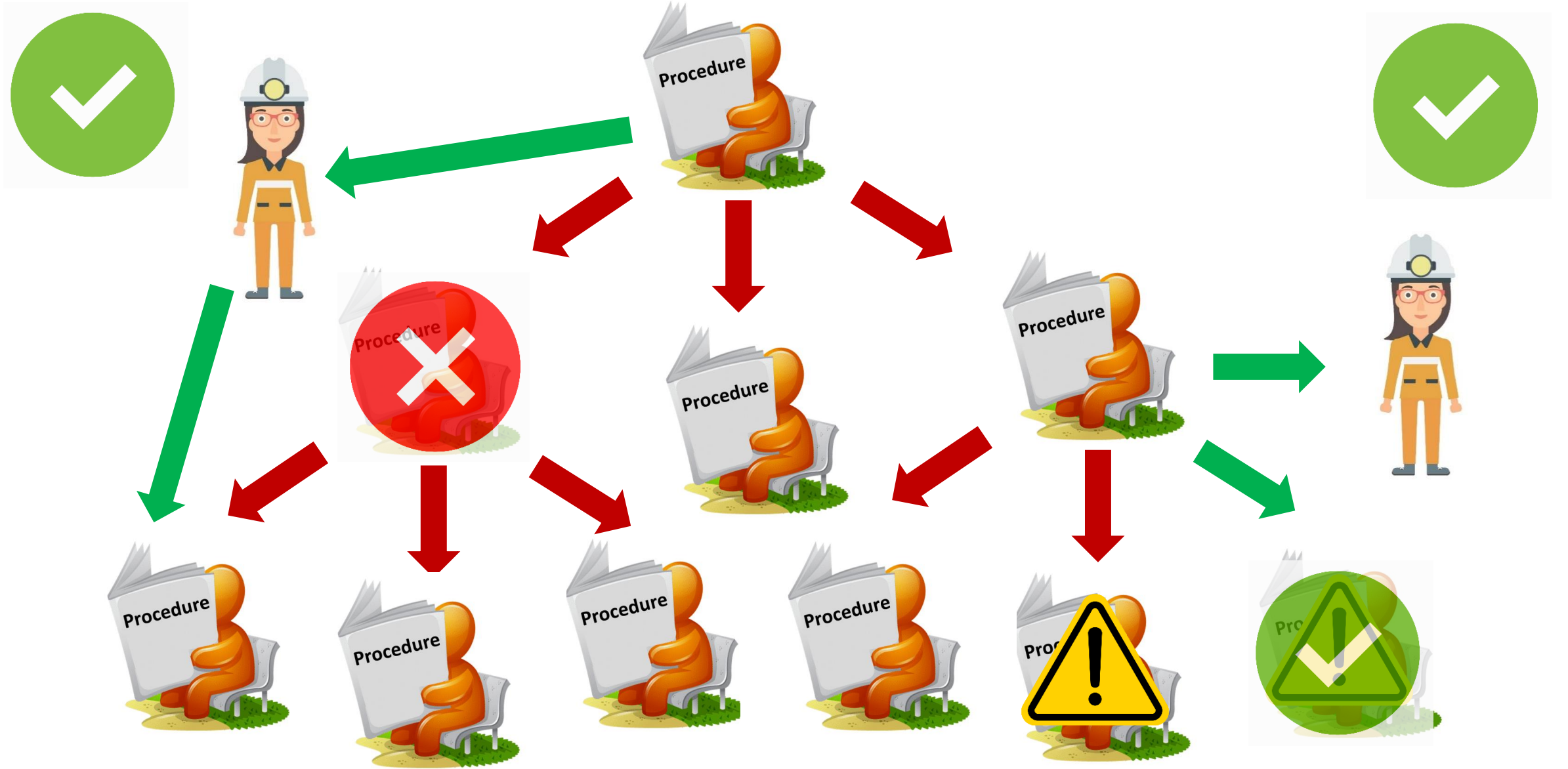


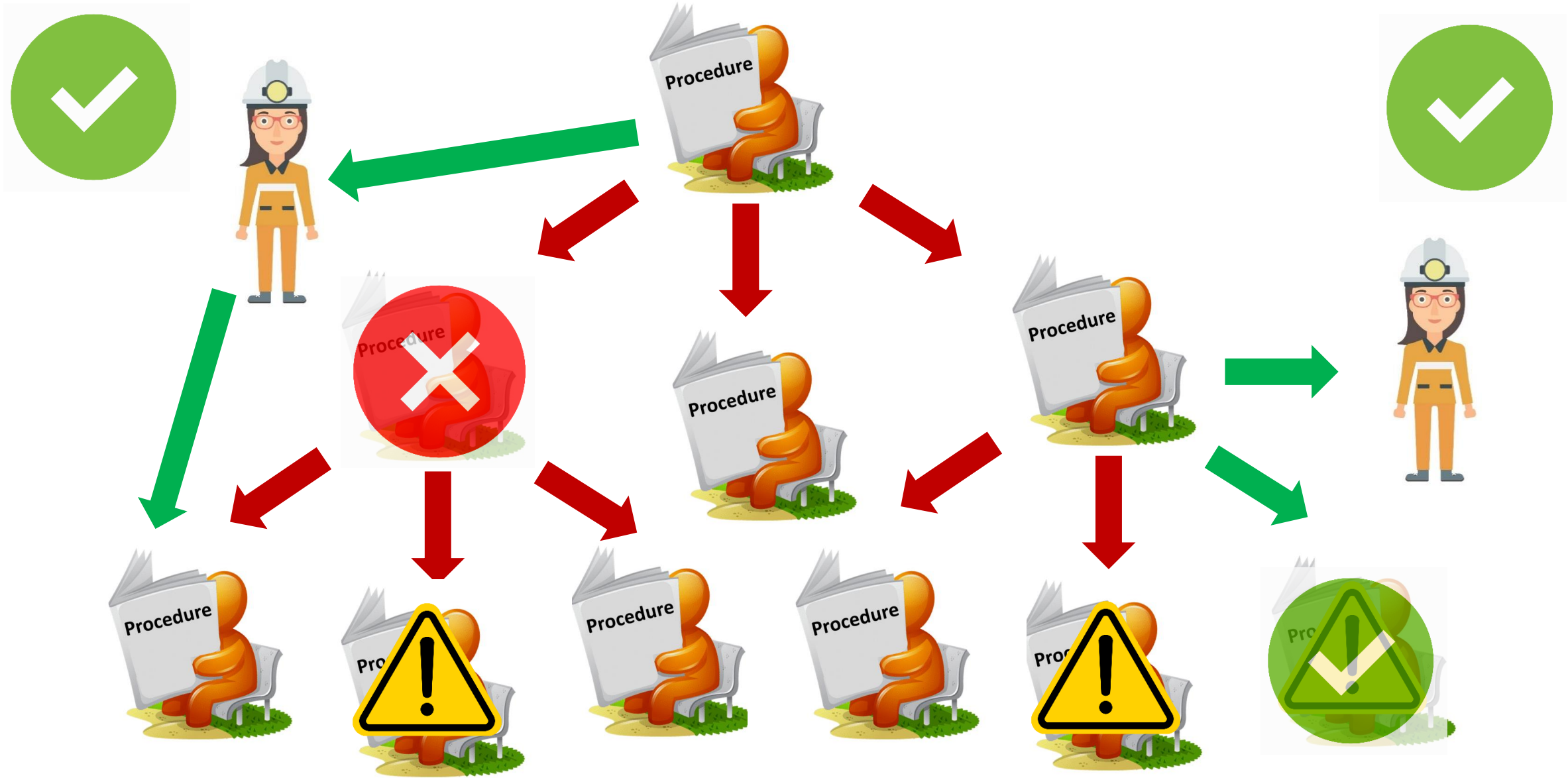




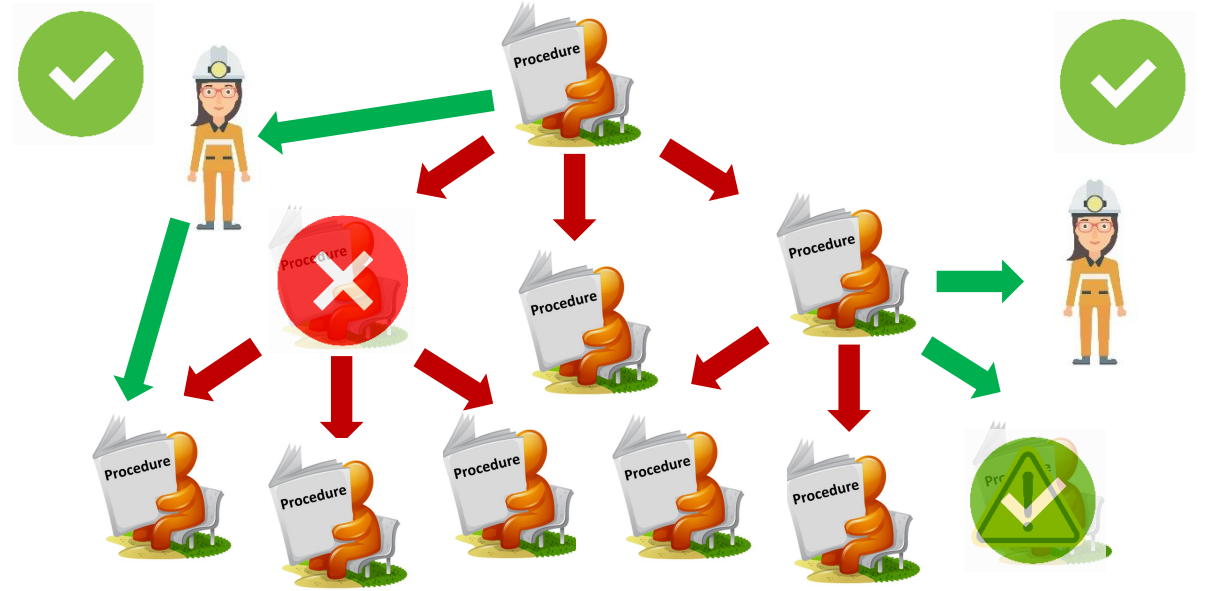
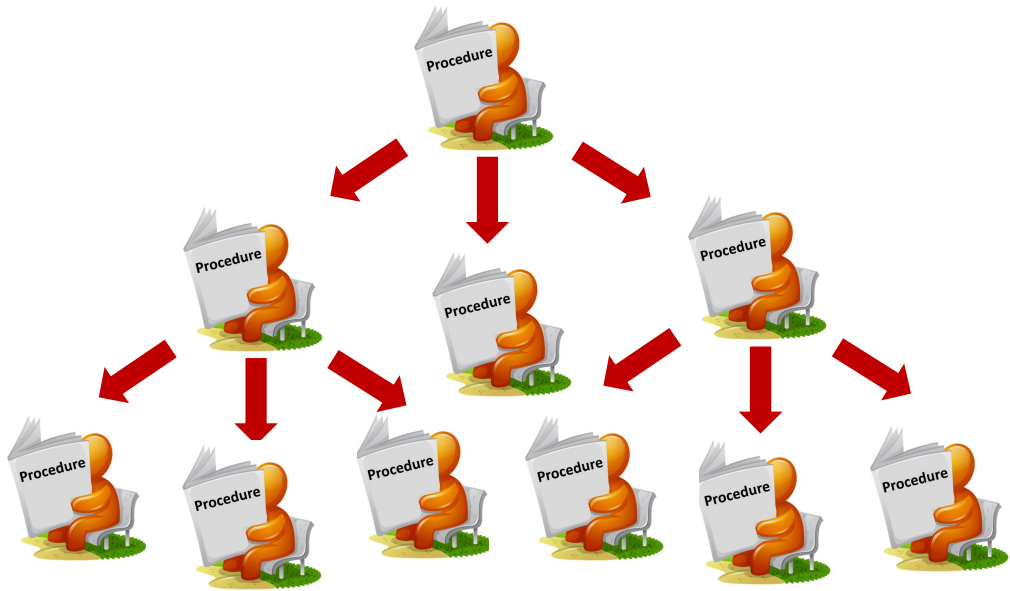




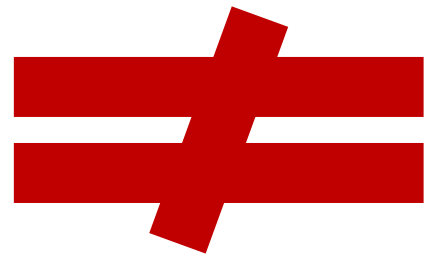




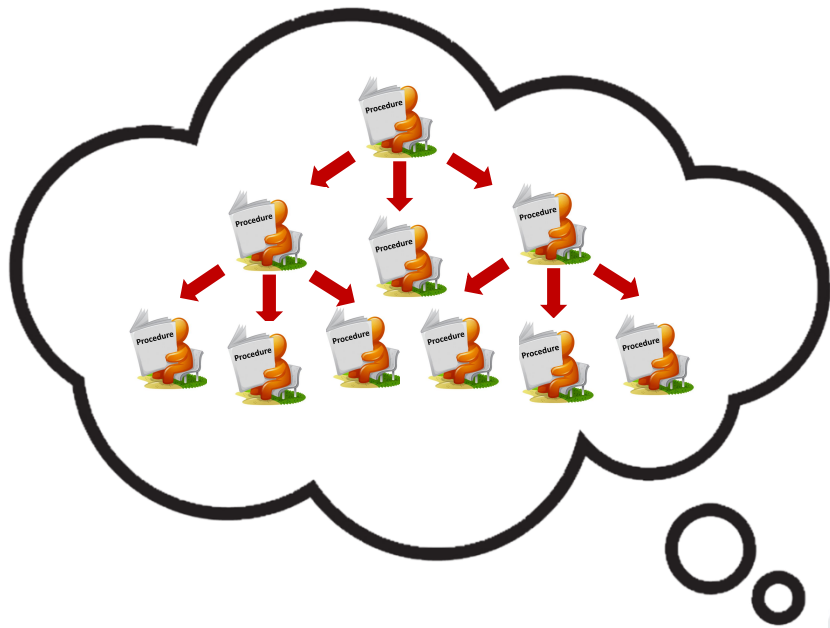




Work As  
Imagined

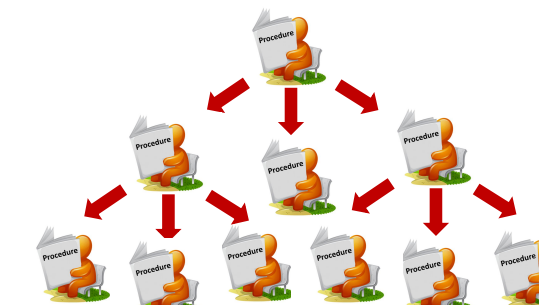
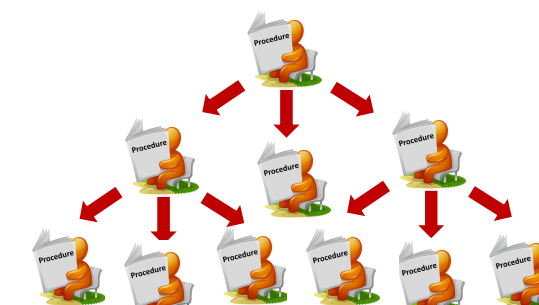
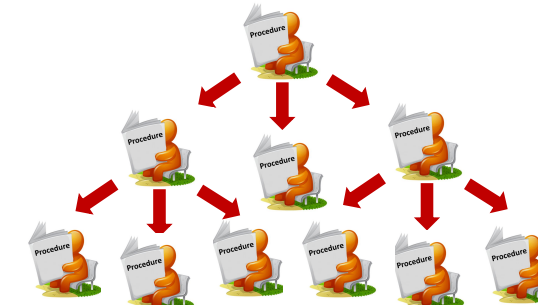
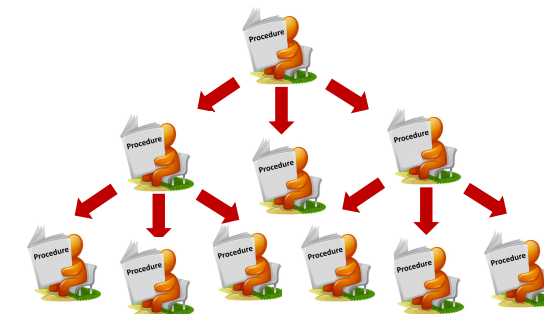
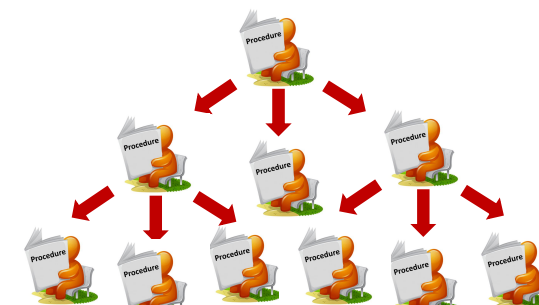
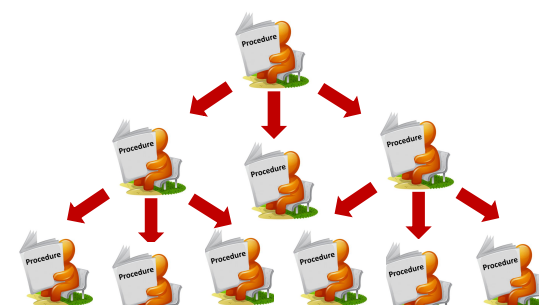
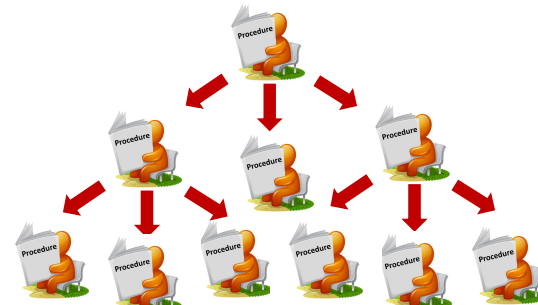
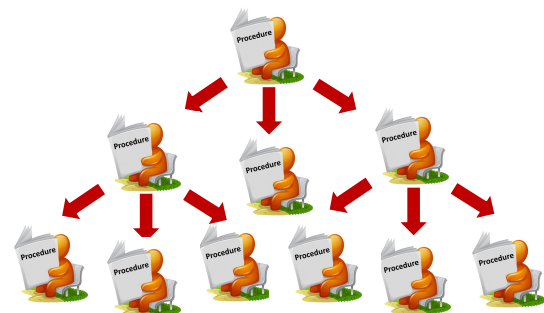
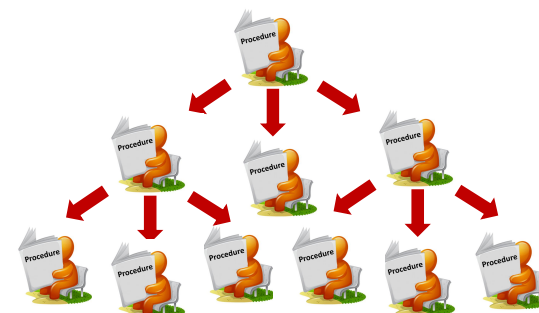
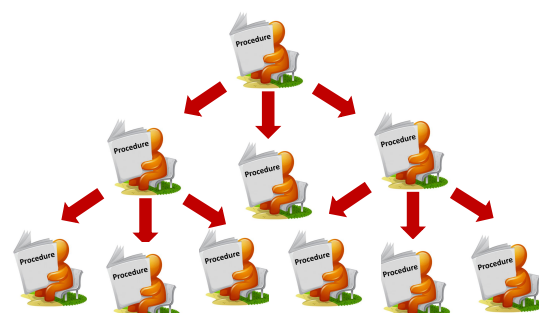
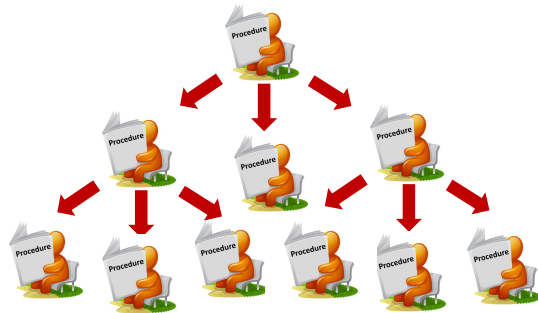
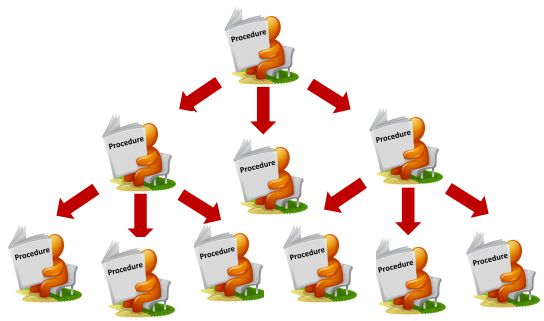


Work As  
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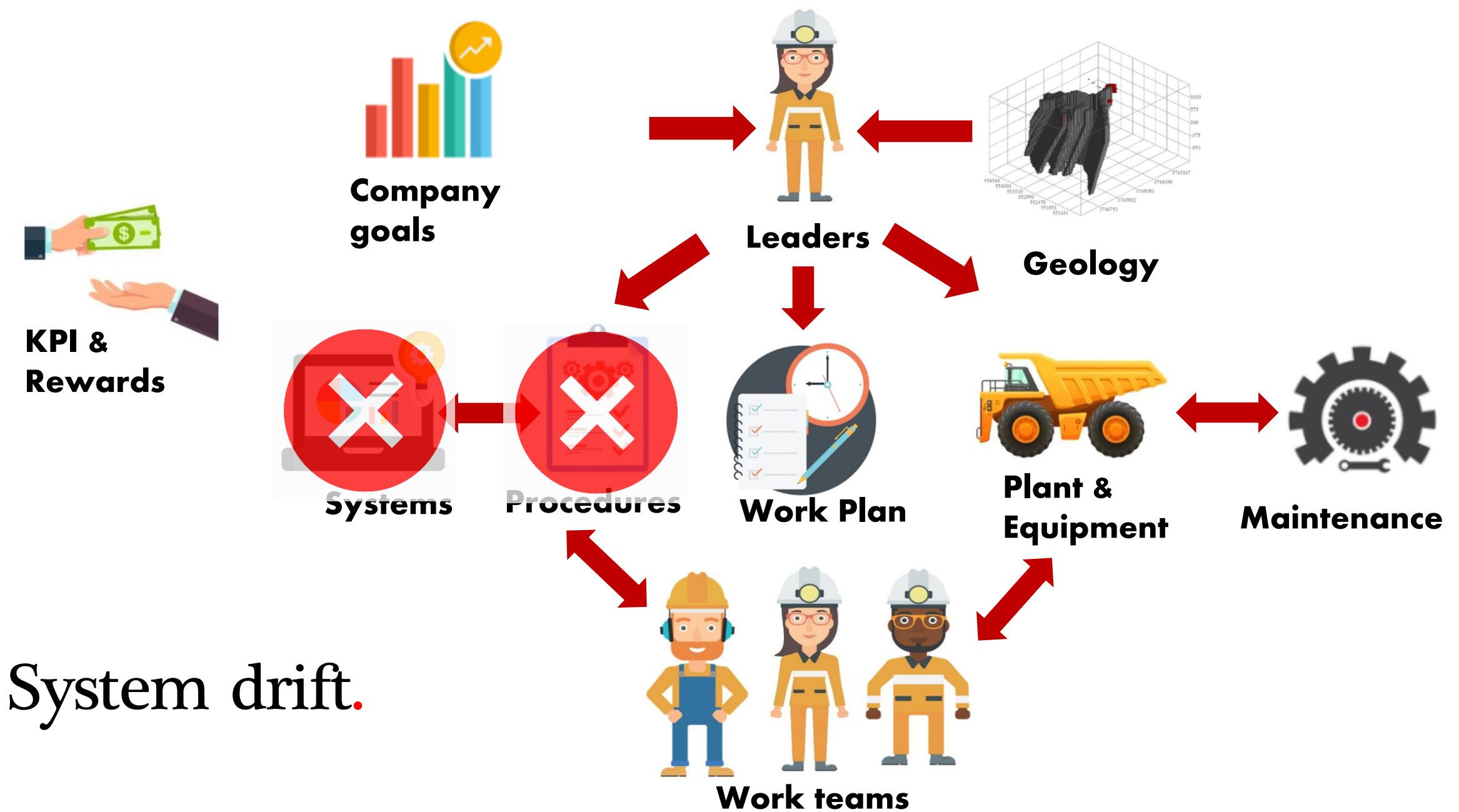
# Drift Into Failure.



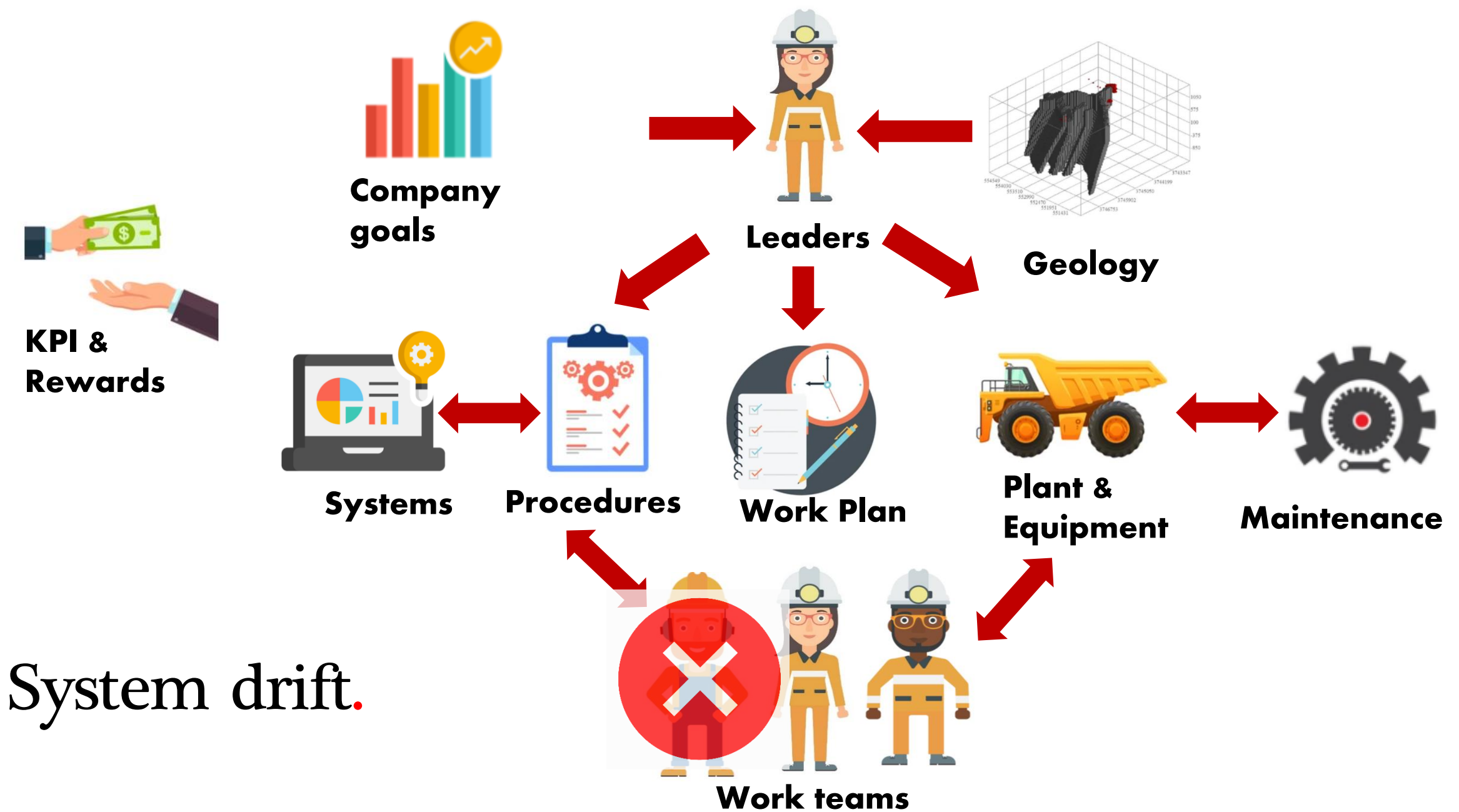


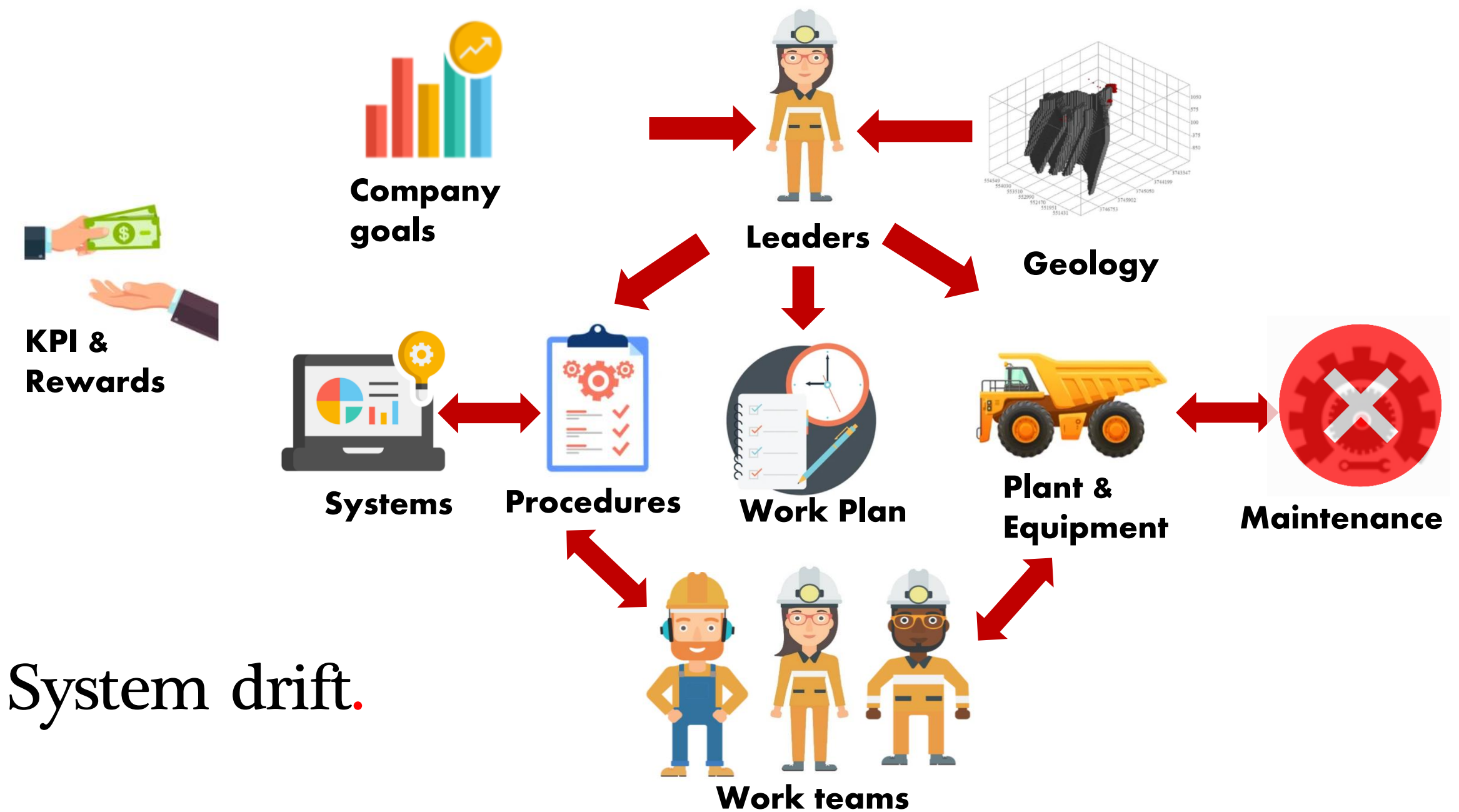
# System components.













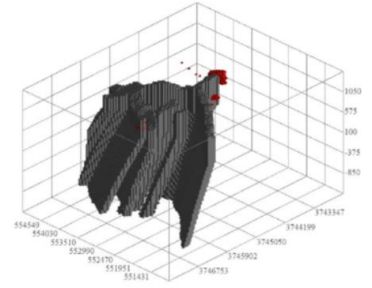
**KPI & Rewards**



**Company goals**



**Leaders**



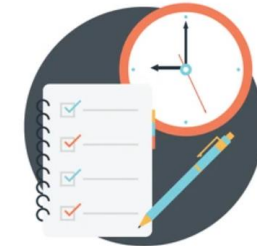
**Geology**



**Systems**



**Procedures**



**Work Plan**



**Plant & Equipment**

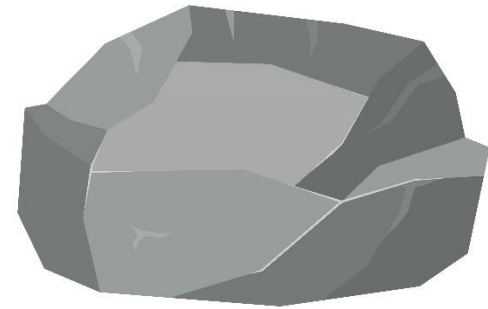


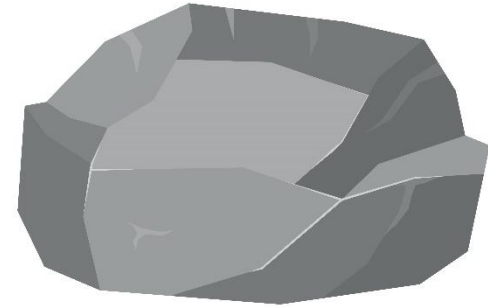
**Maintenance**



**Work teams**

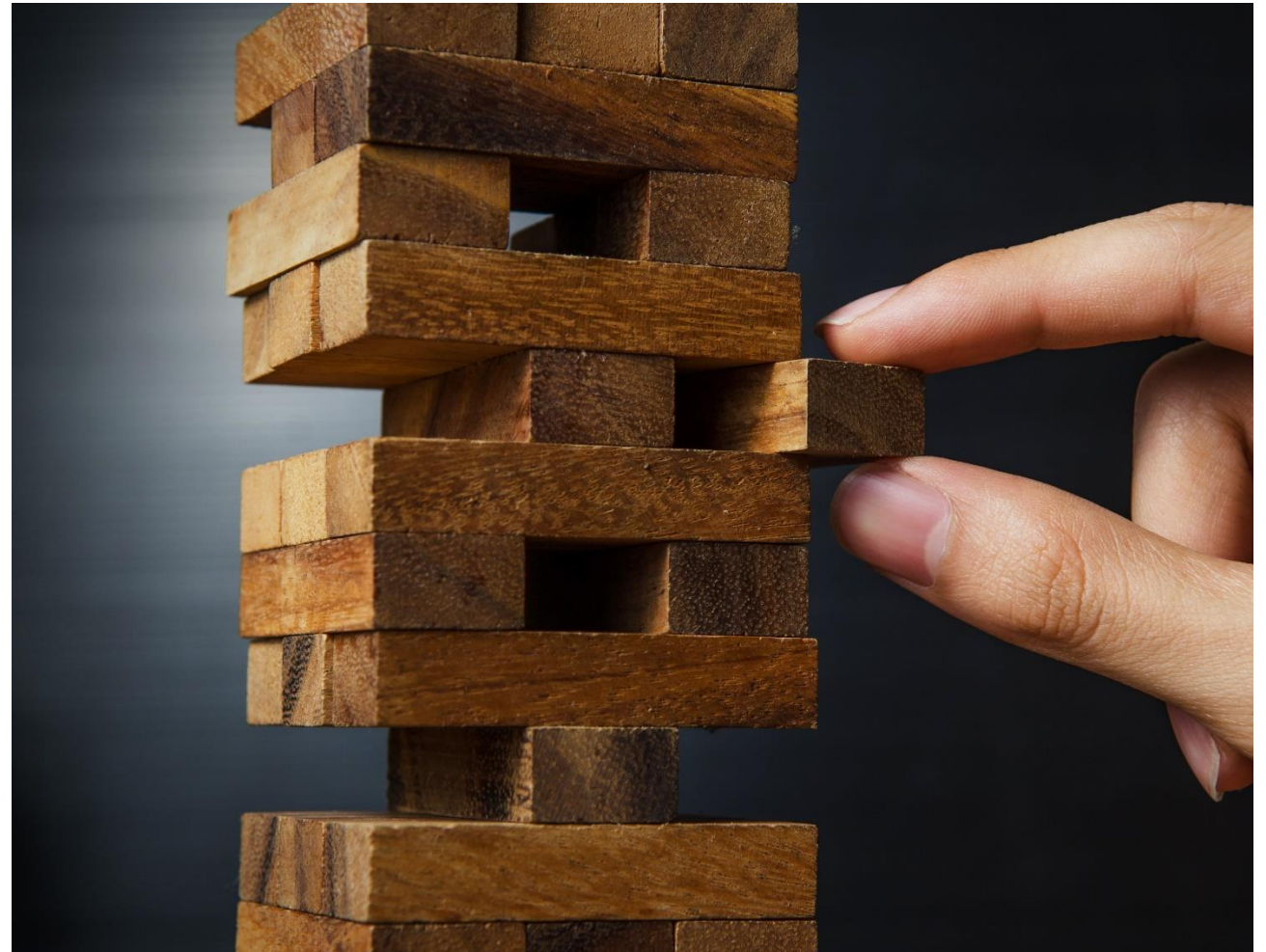
*System drift.*





# Incident

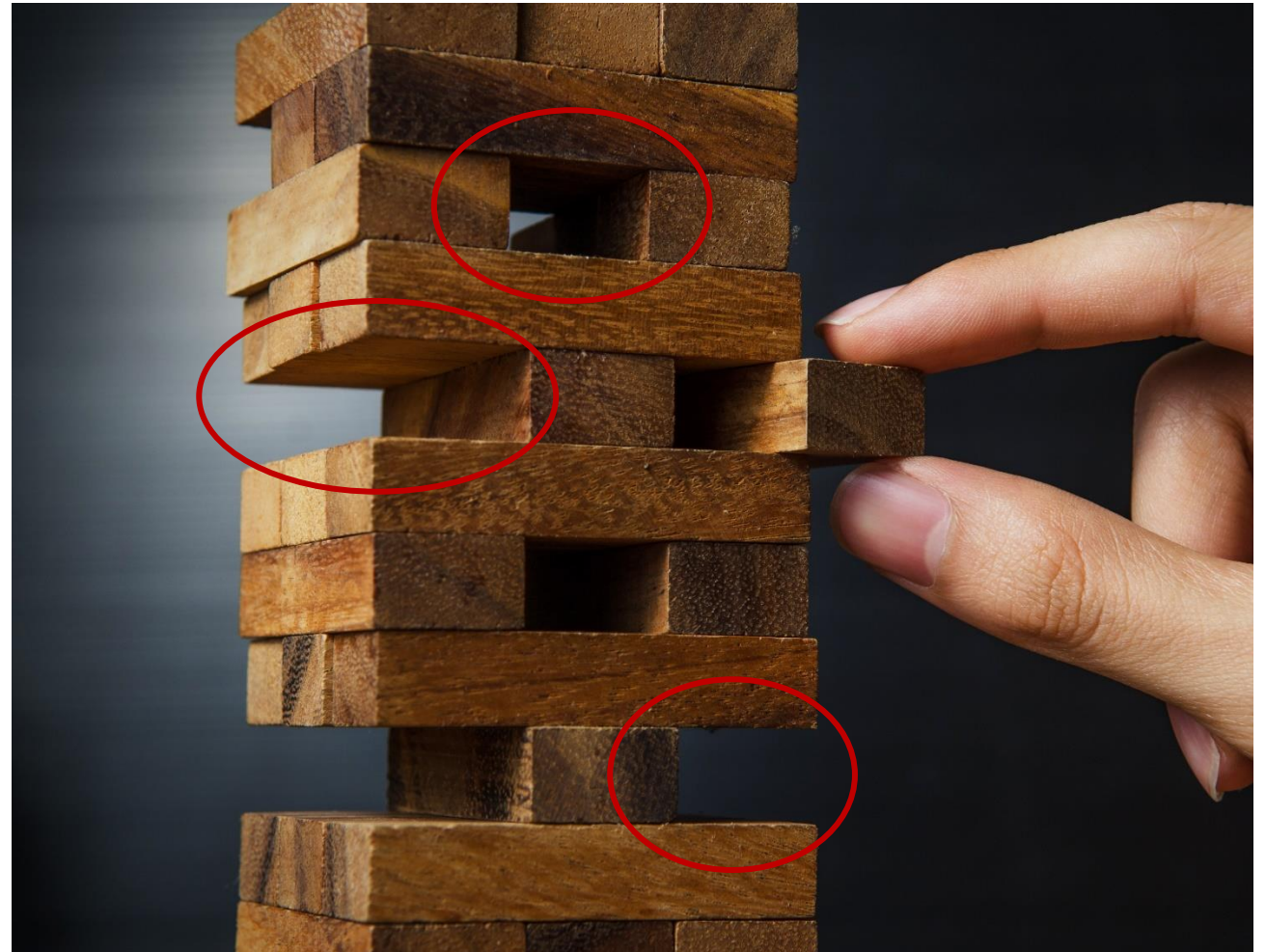
# Jenga.



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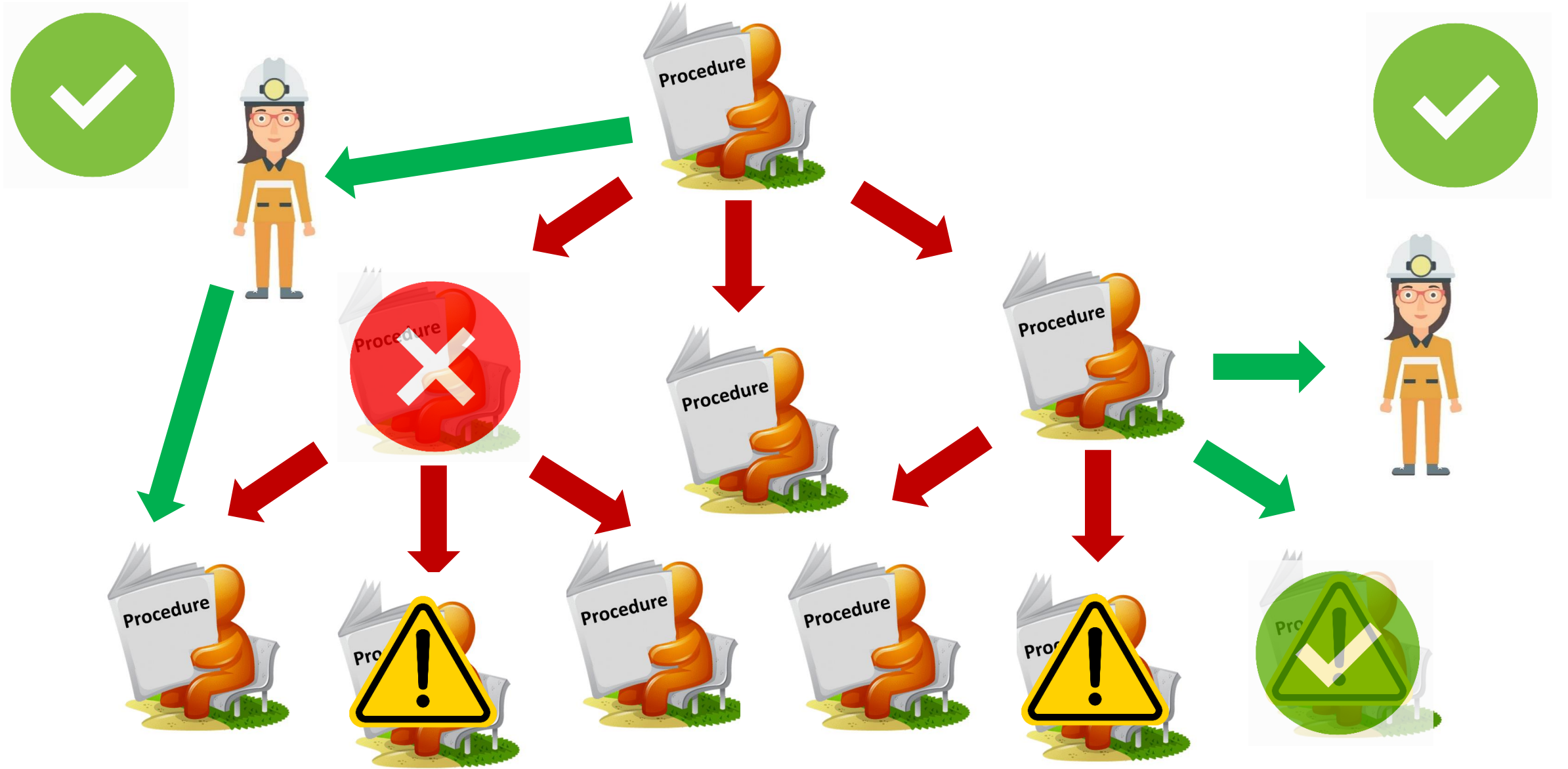




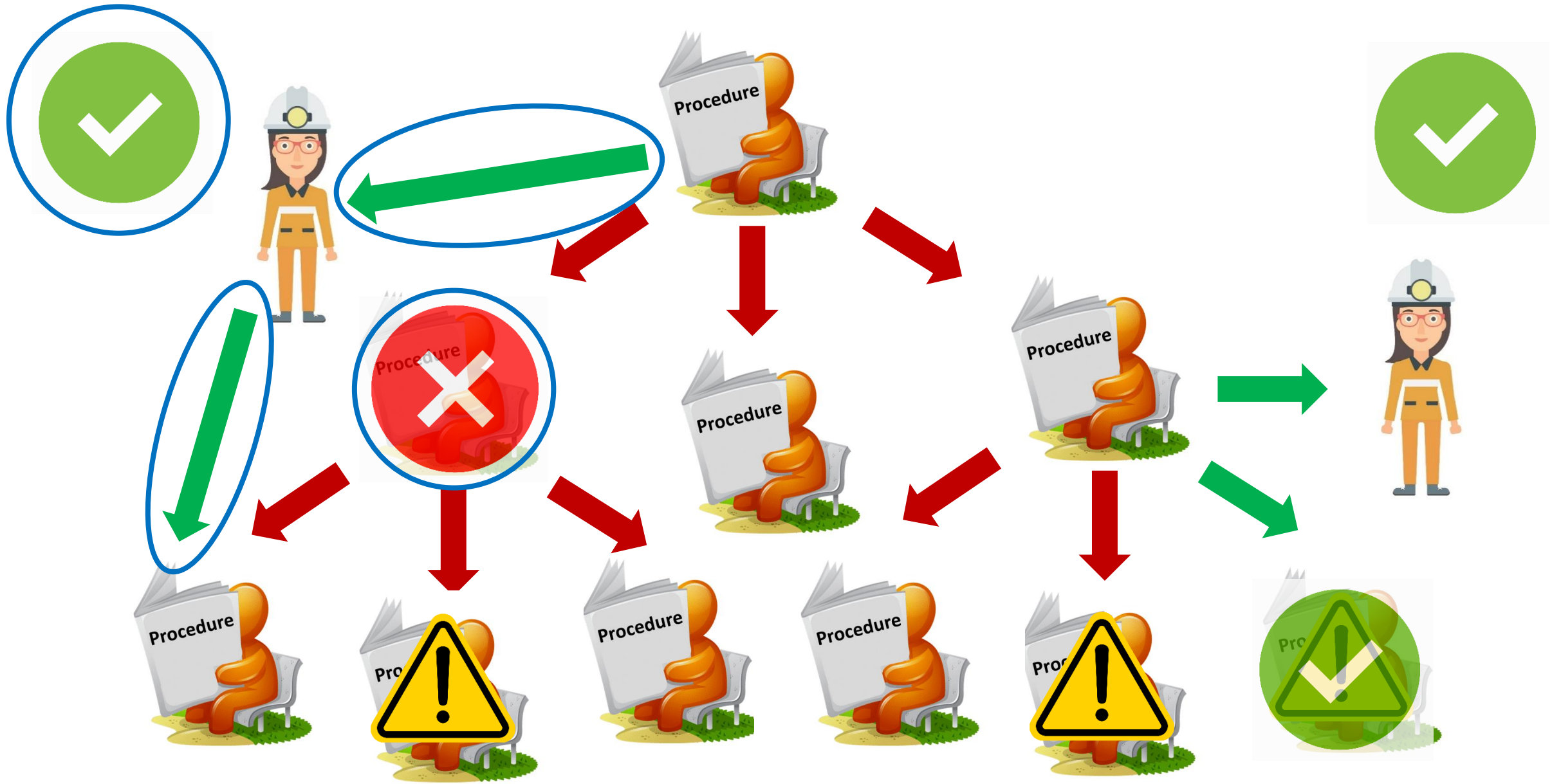
# High Reliability Organisations.

# Predictable Organisations.

# Learning Organisations.



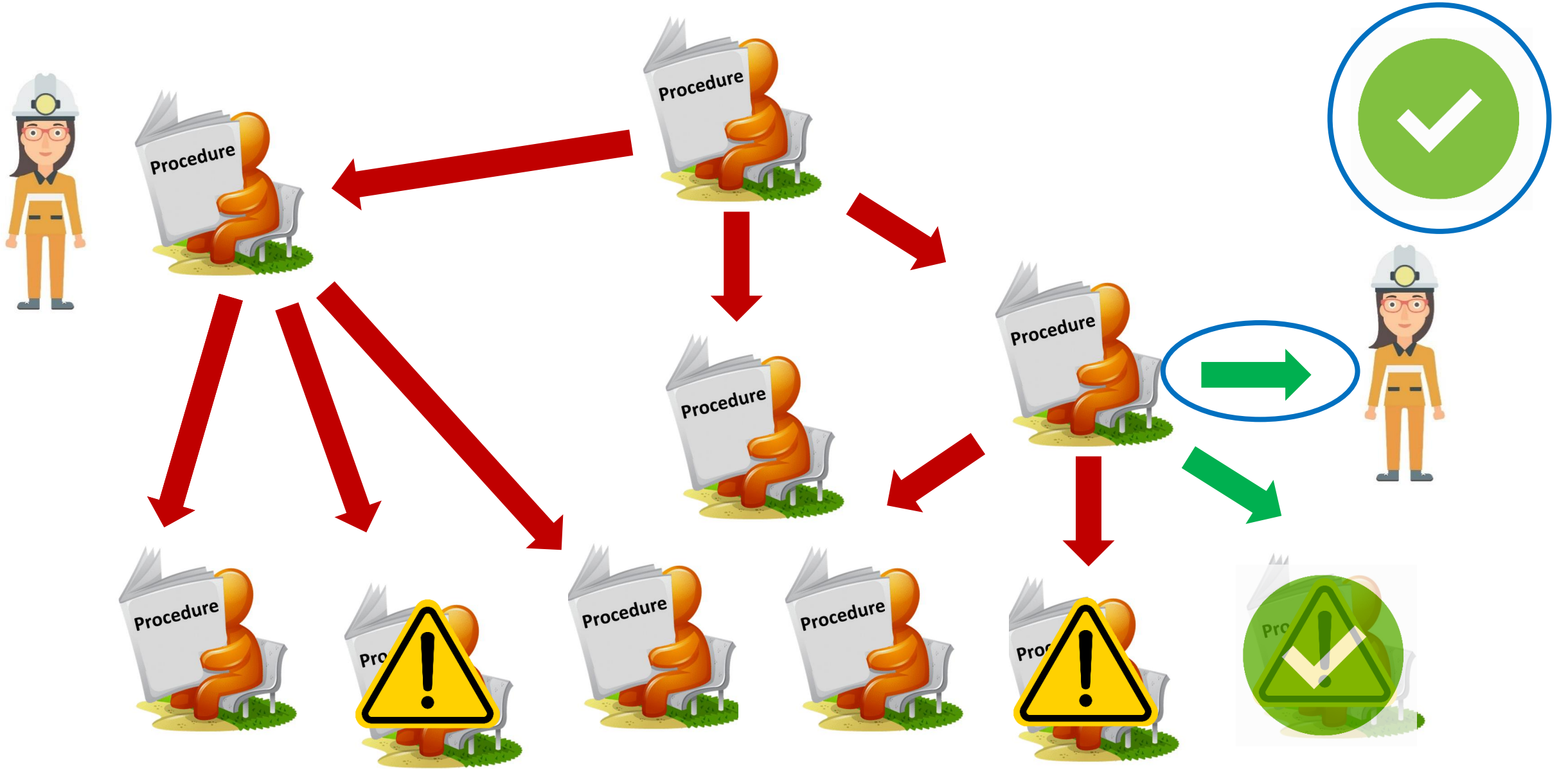


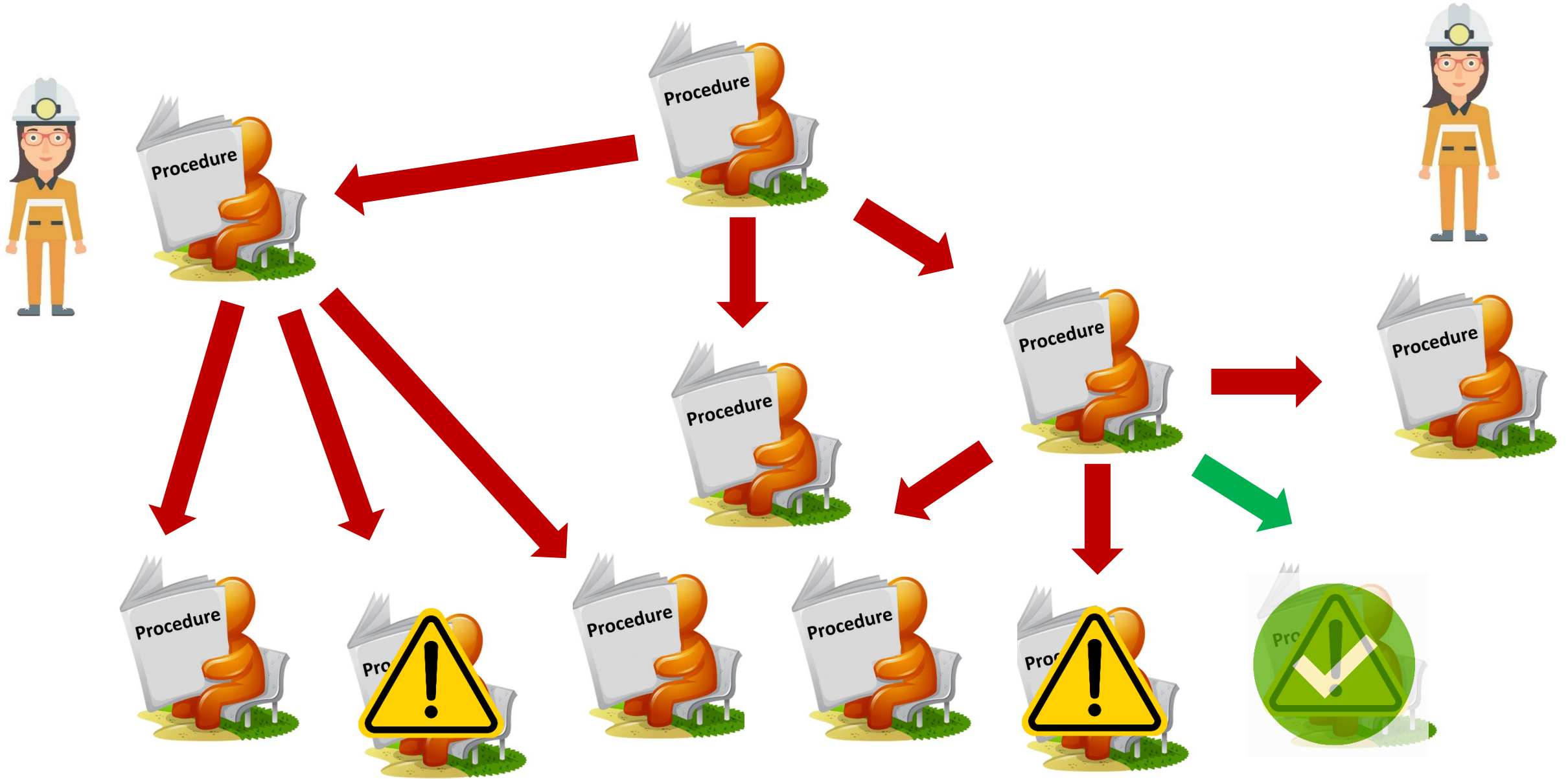


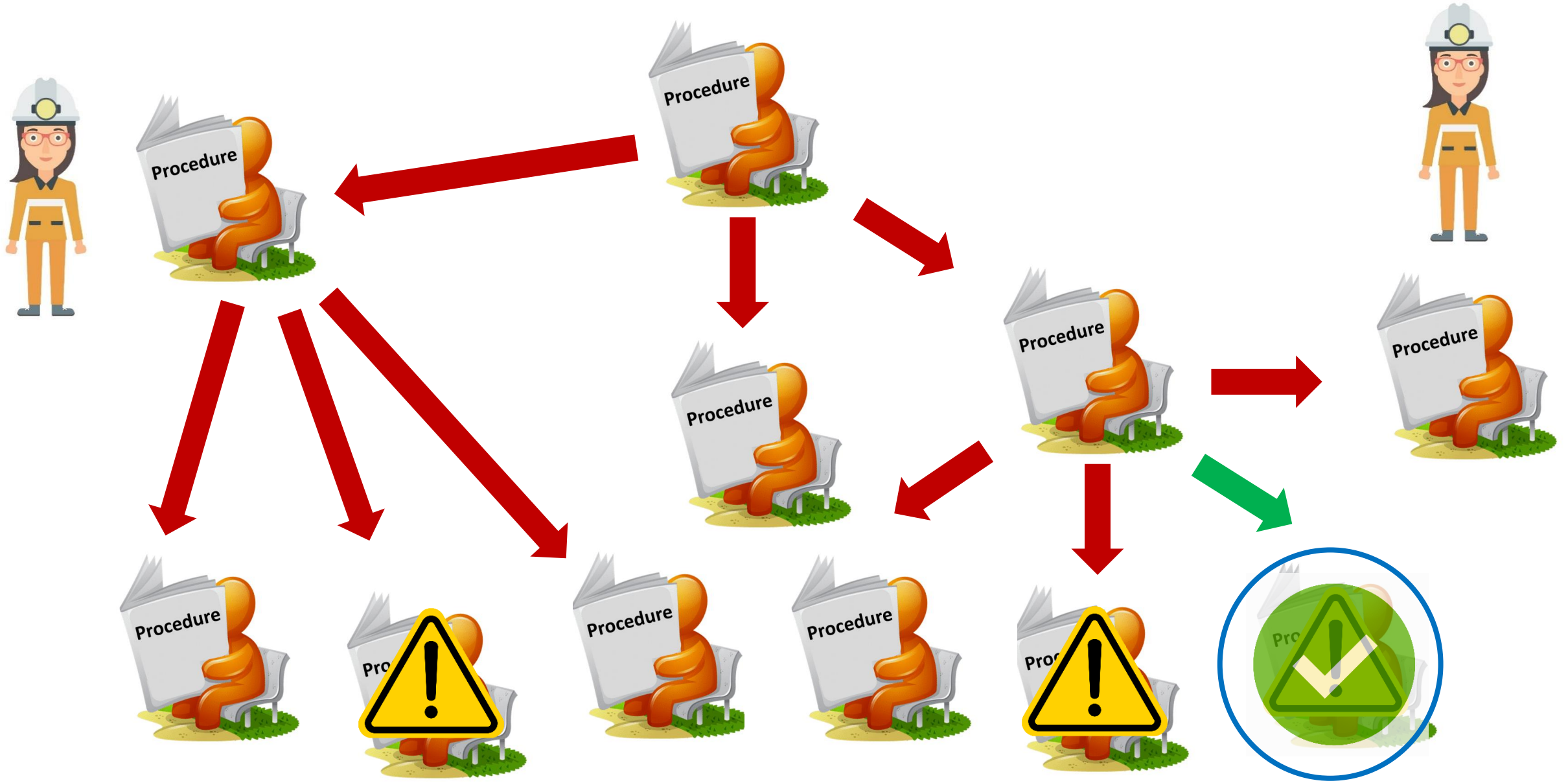


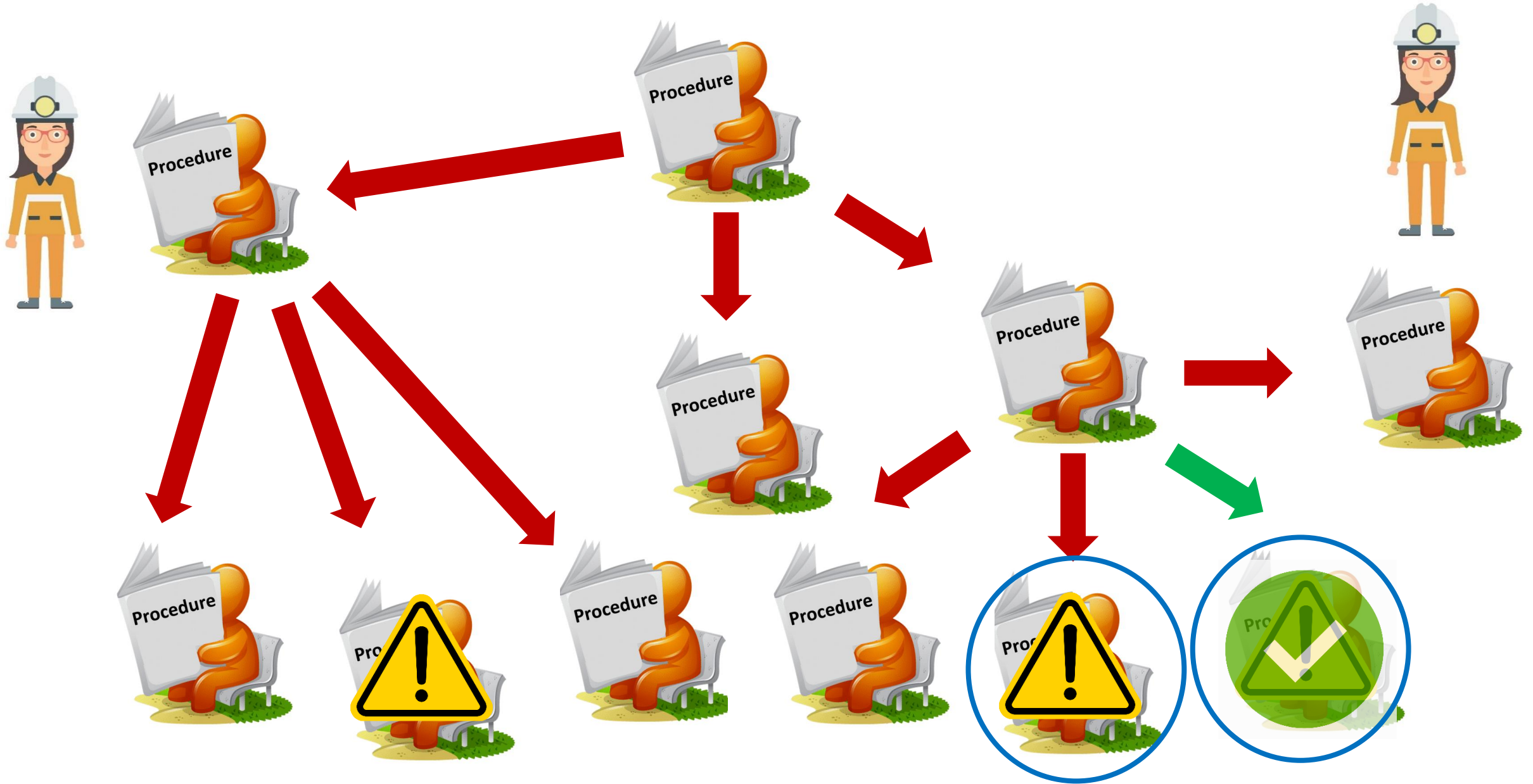


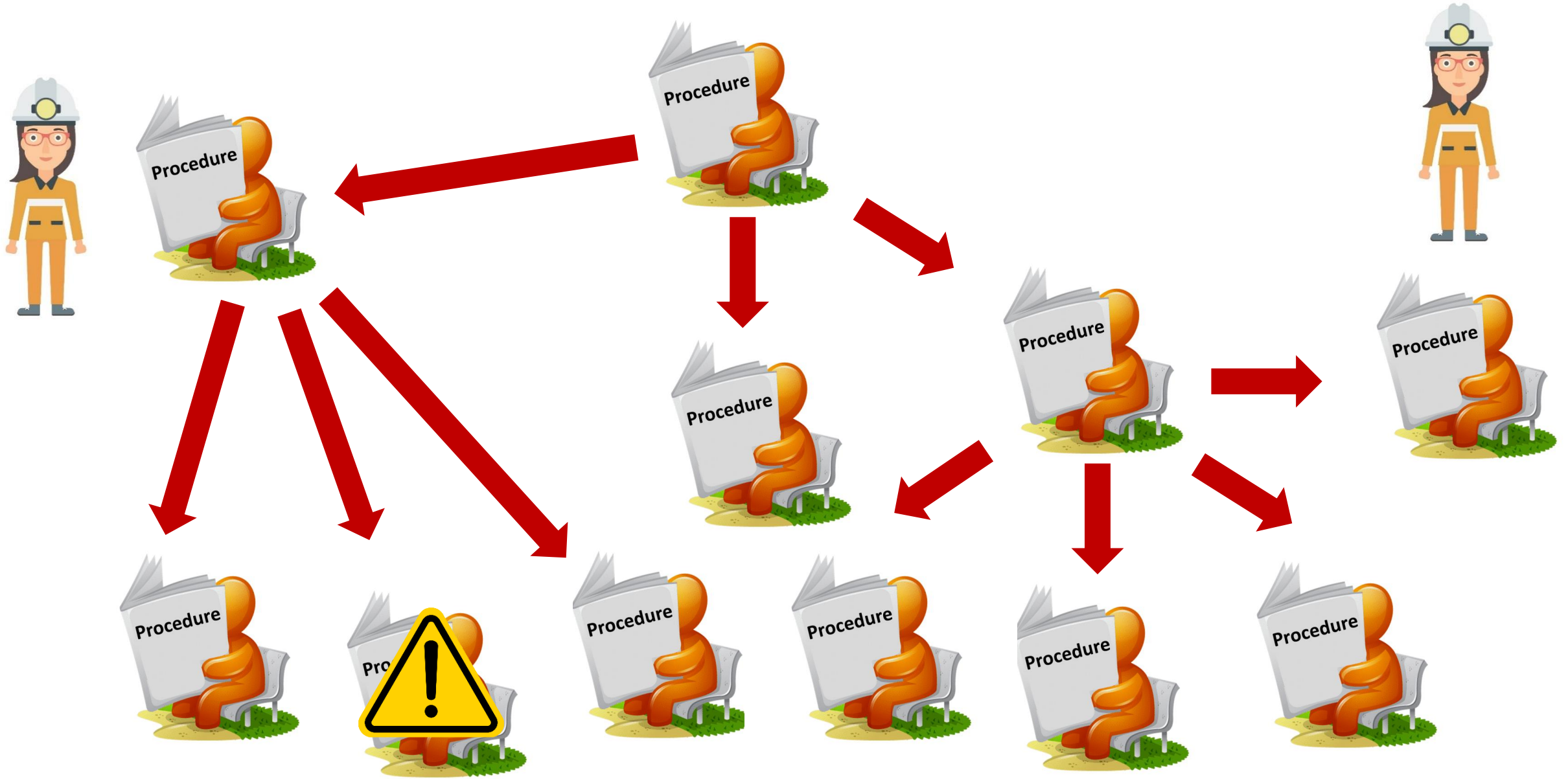


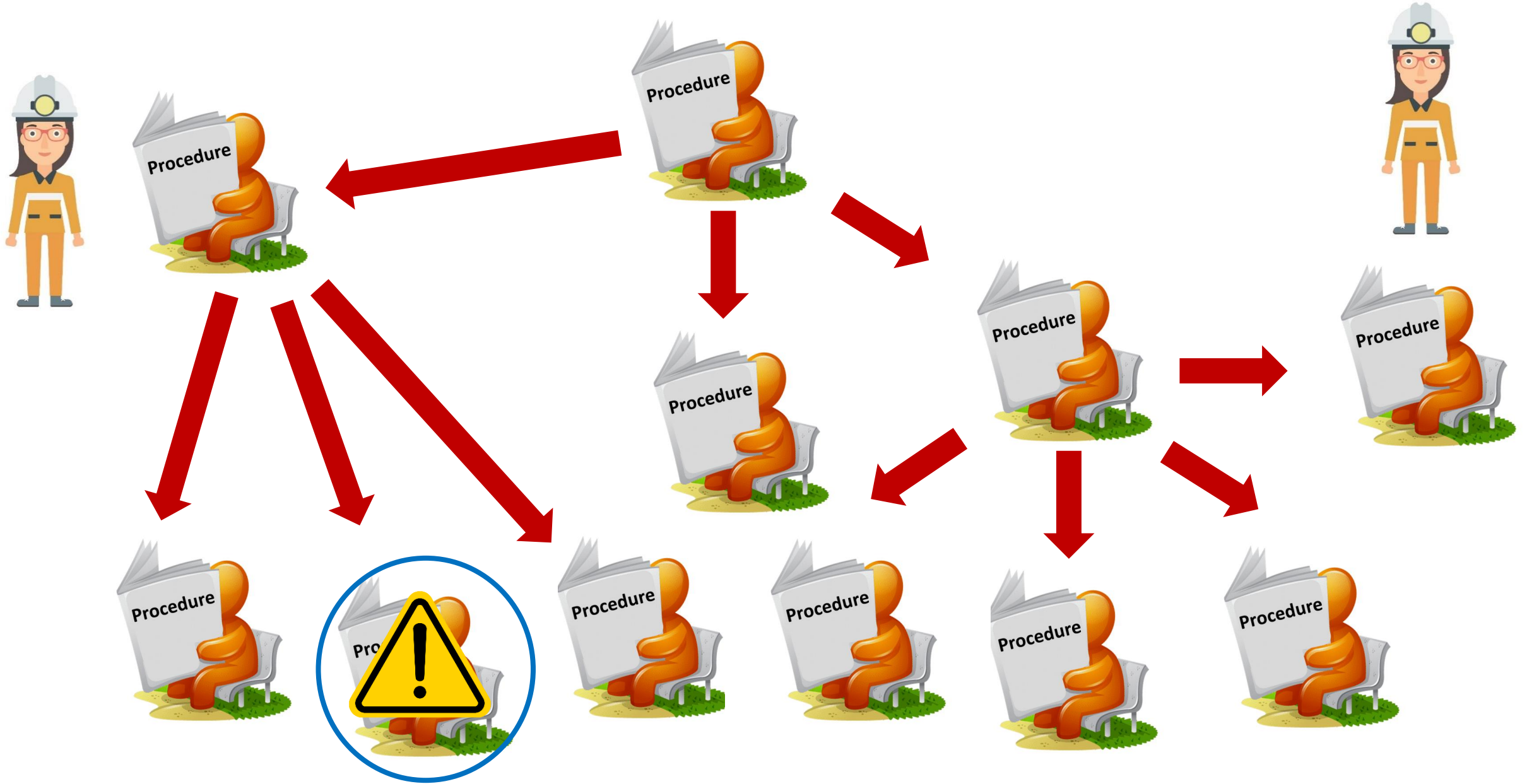


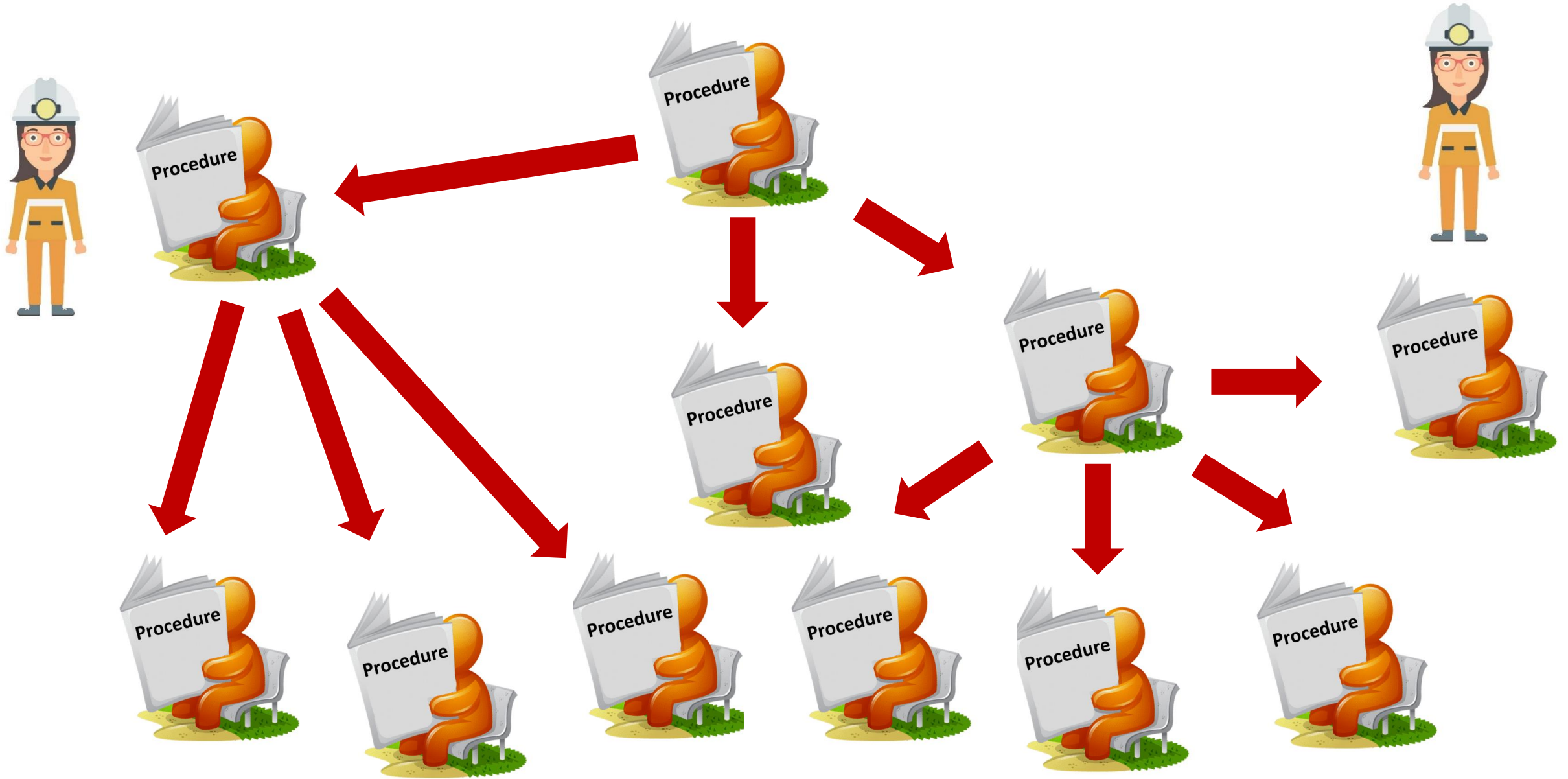






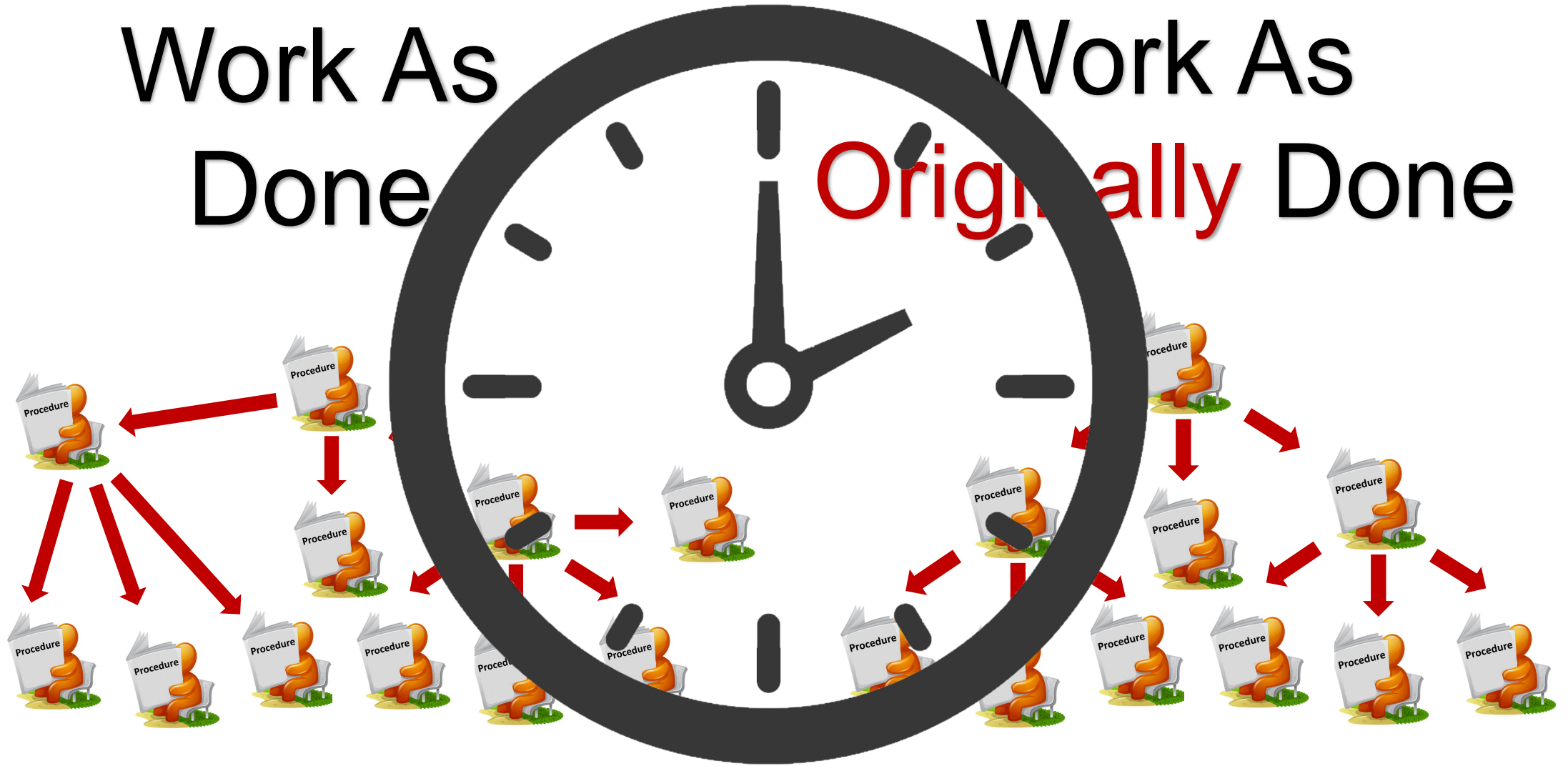






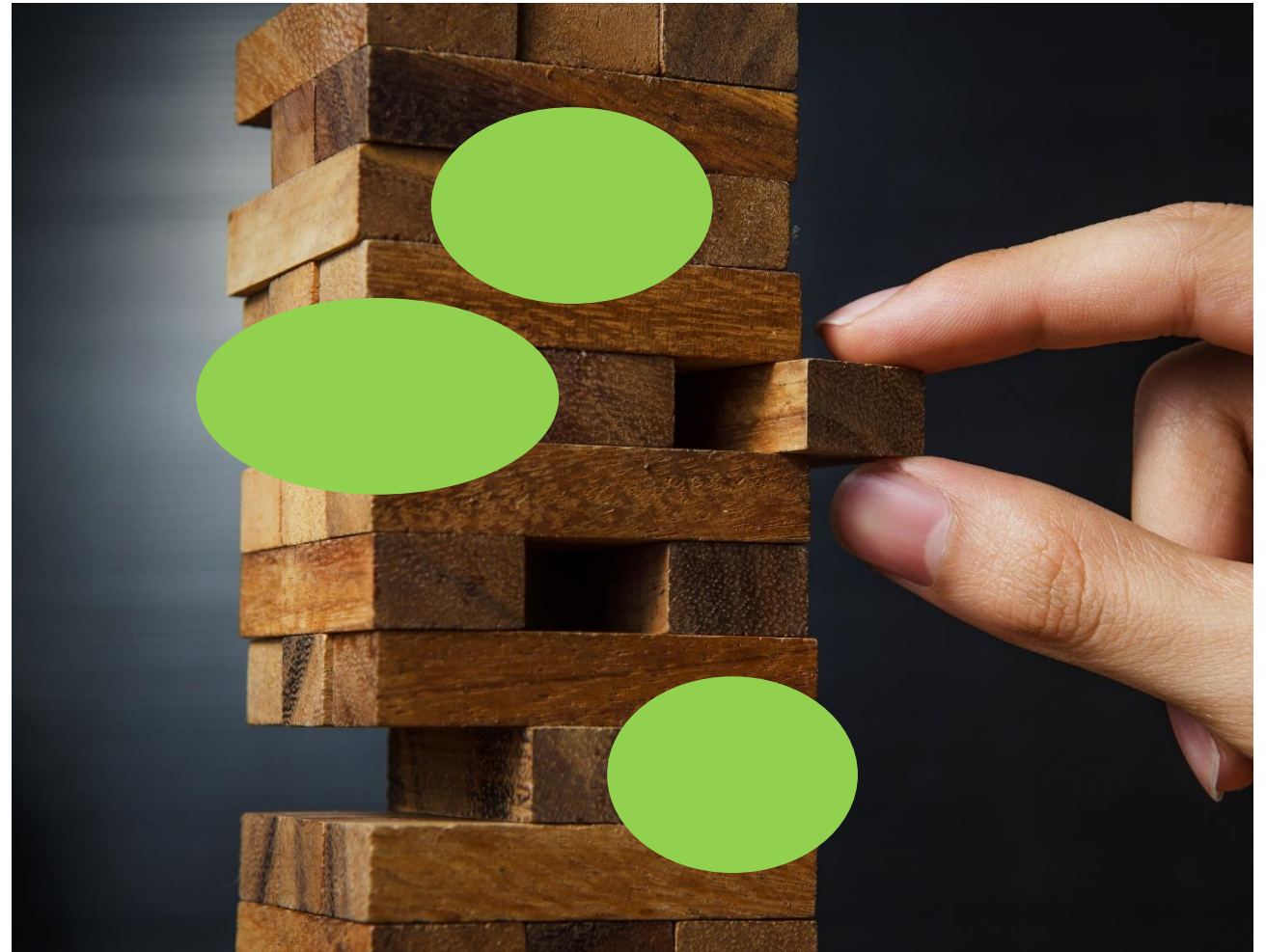
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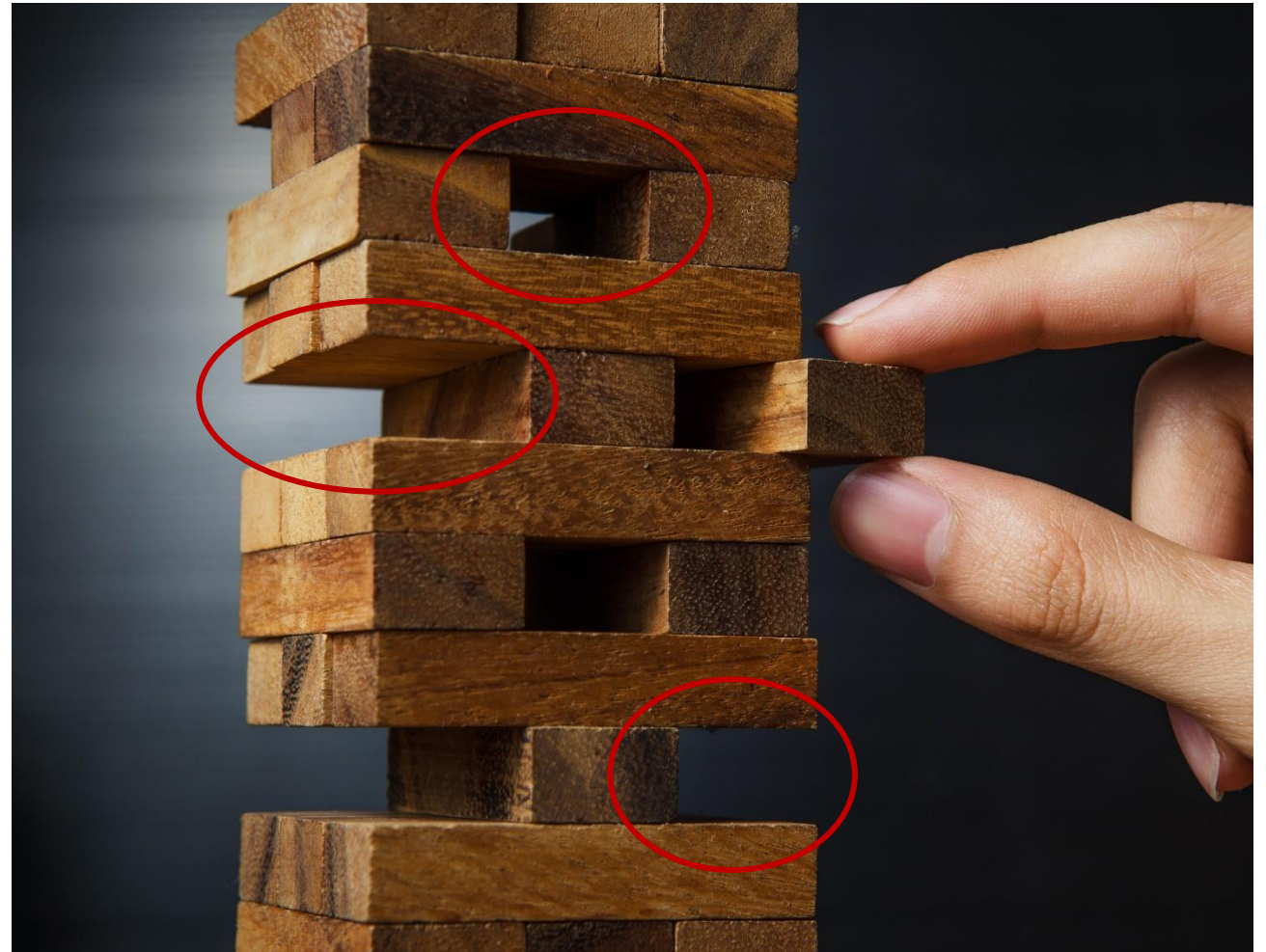




# Going Badly: Hiding Holes.



# Going Well: Identifying Holes.



'Safety'  
not in  
the title

