



Changing minds—‘a white flag’

by J.L. Viljoen*

Synopsis

It has long been the drive of the industry and all operations to create an environment that is free of injury and illness. We have come a long way; the leaders, executives, managers, supervisors and workers are to be commended for relentlessly driving to create, what I call a ‘White Flag Day Every Day’. Yet I am also aware of the huge shift we still need to create in the industry, on the operations and in the workplaces to have them free of injury and illness.

Keywords

People, values, care, trust, belief.

I was later appointed at Mponeng and created a culture of ‘care’. The saying was adopted by the whole team. The progress was good, results trending in the correct direction, and the mine achieved its first million fatality-free shifts in its 21 years. In this time we also saw a shift in behaviour and belief. One of my loco operators had both his legs amputated in a loco accident. On my visit to try to console him, he said: ‘Double Pak, you always say we do not come to the mine to be injured. Look at me. Is this what you meant? How can I continue to care for the ones I love?’ I was filled with a sense of regret and failure. After this and some reflection I changed my saying, with the support of labour leadership, to, ‘No one comes to work here to be injured’. I personally needed to experience this pain and come to this realization to change my behaviour. The consequence of this is that I now absolutely believe that we can operate with a white flag day every day. So how do I get you and you and you to believe the same?

Introduction

Making the shift is a process: one has to adapt as one moves forward. As the general manager of Savuka in the late 1990s, I coined a phrase, ‘No one comes to the mine to die’. This was the basis from which we approached our safety programme to define what consequence we would not accept. We had some good results but we were not always successful.

I was transferred to Bambanani in the Free State. In my mind, it was one of the toughest operations in the country, but it had a group of people that had immense willpower: despite the challenges, they always remained positive in their approach and outlook. We lost four of our colleagues in a large seismic event. This was devastating, and even more so when at the memorial an old team leader who worked with me at Savuka approached me and stated: ‘Double Pak, you always say that no one comes to the mine to die, but there lie two of my sons. Is that what you meant?’. I was shocked and changed my saying and belief to: ‘Nobody comes to work at Bambanani to be injured’. In my mind this shifted and reduced the consequences.

AngloGold Ashanti Southern Africa Division

The division has the deepest operations in the world and is located in the Carletonville, Fochville and Klerksdorp areas. We employ approximately 36 000 people at the seven underground operations and one surface operation. The company has a vision to be the leading mining company and clearly states that people are our business and our business is people. The values according to which we live, are that safety is our first value; we treat each other with dignity and respect while at the same time we value diversity; we are accountable for our actions; and undertake to deliver on our commitments. We care for the

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communities and societies in which we operate and they will be better off for us being there. We have respect for the environment and the legacy we leave behind.

The two graphs in Figures 1 and 2 indicate the progress that we have made against the milestones and the number of accidents that we have reduced over the period. The actions that are described below are the essence of what we have done to improve the safety performance. The health elements are not discussed, but one must understand they are a critical element that needs to be addressed if one is going to have any meaningful result.

This is a process and there is no single design that you can copy and paste. You need to work this out for yourself, but need to be relentless in your efforts.

The white flag

The white flag is a symbol with which every person in the organization can associate. It represents a set of beliefs: that you can operate without accidents, that you can live safety as your first value, and that people are important. The white flag applies to a crew, section, mine and the region as a whole. The white flag is displayed in an area where the people it affects, can see it and know what the status is for their safety performance for the preceding day. It represents an achievement and builds a set of beliefs that it is possible to operate without having any injury. Today’s achievement becomes the next day’s standard. Figure 3 shows the progress in achieving white flags for the region.

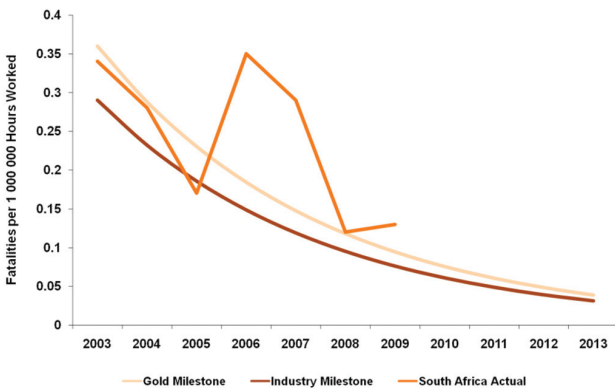


Figure 1—South Africa Division performance against milestones (FIFR)

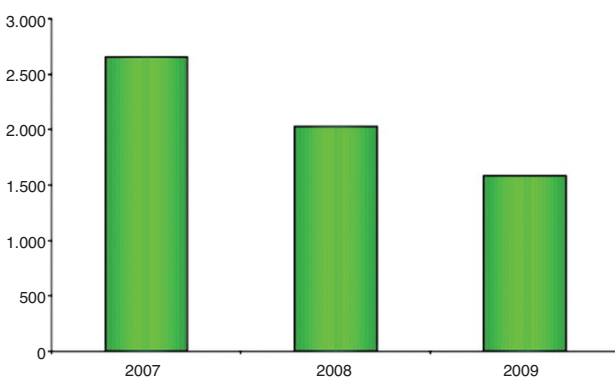


Figure 2—South Africa Division number of accidents

The achievements in Figure 3 mean that 36 000 people have worked in the deepest operations in the world without a single injury for these days. When deep level operations push to increase the number of consecutive days and operational teams measure the number of months with white flags, then you know that having a symbol has created a behaviour change and a personal belief.

The white flag has been the one symbol that has featured in every discussion without people having to say what they believe. Just the reference to the white flag created the understanding of what we are driving right through the organization. The white flag also proved to be the symbol that got the government and labour representatives to the table and enabled them to talk the same language without needing clarification or a bargaining process.

It is ‘OK’

I have this view that the people who come to work at the mine, do not come here not to do their work or to be injured. We as managers and supervisors actually often create an environment in which these people cannot do their work as planned or safely. They are caught up in the daily fight of what is more important—the production or the actions needed to create a workplace that is free from injury or illness. They are often forced into decisions because of the way we design our bonus systems or the fact that they fear their direct supervisors. This predicament escalates right into the senior ranks where the scene is set for how and what will happen. It is ‘OK’ also applies to senior managers when they are in the process of planning, designing or reviewing operations. When you get it wrong here, it just snowballs down the hierarchy and you will take away any discretionary effort that would have taken place.

To overcome this, as head of the division, I made it very clear that, ‘It is OK to stop a working place if it is not safe; in fact it is your duty to stop it’. This created serious conflict and dispute between the ranks, but the fact is that everyone understood that we were trying to create a white flag day everyday, and a behaviour shift was created. It shifts responsibility to the individual without his having to weigh up what is more important.

The question should then be asked what the roles of the supervisor and appointed safety representative are. They have a designated responsibility and need to be held

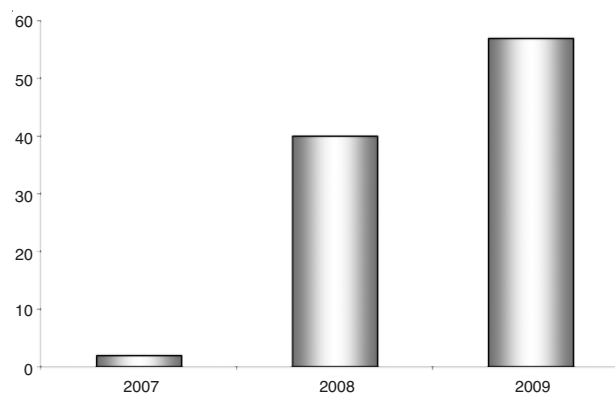


Figure 3—Number of white flags, South Africa Division white flags days

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accountable for that. Issues are often considered to be routine, but they are critical to create the environment in which the individual will be operating for that specific shift. After being allocated work, each individual is trusted to execute the work that has been allocated to him to get the team to achieve the agreed output. It is while the individual is performing these tasks that he continuously has to evaluate the situation. (In safety terms, he is performing a ‘continuous risk assessment’.)

The T principle

We have coached and trained the T principle to every employee and it is reiterated that it ‘OK’ to stop a working place if it is not safe:

- Treat
- Terminate
- Transfer but never
- Tolerate.

This principle has created an understanding of what is expected from every person to create a workplace where he can operate without being exposed to injury. This has helped people understand the importance of creating a white flag day every day.

CARE

CARE can stand for commitment, accountability, responsibility and empowerment, but in this case it means that you are really important and that I do really care for you as a person and for what you represent. We are individuals that have our own personal aspirations, goals and views on life, and we come from unique backgrounds. In order to create a shared future and a successful business, we need to treat each other with dignity and respect and really care for each other. This will create a relationship of support for each other and will allow each of us to achieve our personal goals and contribute to the overall success of our business.

The circle of influence plays a significant role in the way that we value the impact that we have. The circle describes you at the centre as being unique and special; that you are responsible for the choices you make or fail to make in life; and therefore you need to take control of your life. You cannot blame anyone for where you are. The second circle represents your family and loved ones and their absolute dependence on your influence. The third circle is about your fellow colleagues that come to work for exactly the same reason as you do. Do not underestimate the influence you have on them. To live the value of CARE, you need to understand it as a whole thing, not just at work but at home and in the communities. It does not just mean being nice, but being honest and deliberate, and holding people to account. How does one measure care? Care is evident when people feel valued and part of the team and would do absolutely anything to make the world they affect a better place, no matter what it takes. Care is felt and it creates trust and respect.

A learning culture

Every indication is that all the time and effort we spend on addressing safety is reactive: the incident has occurred and the loss is measurable. Imagine you can use all this time,

which I term the positive time zone, applying your energy to preventing the accident or loss. The focus and effort would be in creating an environment in which people can operate without the fear of injury or exposure to illness.

While on this journey of creating a white flag every day, you will have failures. We have had them, but we have undertaken to do everything we can to prevent a repeat of an accident that has the same causes or circumstances as an incident that we have investigated. A process has been put in place to ensure that the findings, as they become available, are briefed in a consistent manner to those employees that could potentially be exposed to a similar risk or situation. As has become practice in South Africa, the affected operations will be stopped, to assess if a similar risk or condition exists on the operation. In support of the stoppage protocol, the full agreed audit will take place.

The first Monday after an accident, all the operations’ executives will meet to discuss the facts and what has been learnt, through a presentation by the responsible managers. At this session the required technical specialist will participate: rock engineers for a seismic event or fall of ground; engineers for a transport or machinery accident; and training and safety specialists in attendance at every review. This feedback will then be fed through the operational structures to the relevant teams and responsible individuals. This will be followed by a formal briefing of the stoppage audit through the divisions’ executive.

As soon as this has been done, a peer review will take place where a cross-sectional team, led by a general manager, will review the systems, planning, training manuals and the risk management process. The results of this will then be presented by the lead general manager to the first line supervisors. This ensures a consistent message and in this process learning is created. The whole process has created consistent measurement and unified training programmes. The benefit of this is that people could move between operations and know what the risks are and have the equivalent competencies. The safety management system tracks the progress and whether the risk identified is being reduced.

5 teen is an audit process of selected areas that have been identified as underperforming or who have the potential to operate at another safety level. A team of technical and experienced operators will visit and evaluate the identified workplace. They are critical and measure the teams against their own approved standards. The audit teams also use what has been learnt, from what has happened in the company and in the industry, to guide the teams on how they are performing and what the risks and exposures are. From here the process is taken further by the operational team with participation of labour and services disciplines, who will plan and design the turnabout and agree on the implementation and time lines for measurement. This participative planning creates the opportunity for involvement and achievement and the creation of white flags.

Partnerships

A white flag is not possible if the alliance partners do not play an active and meaningful role. It is not a case of meetings that are so often held just for the sake of holding them. On our journey we agreed that the relationship and

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partnership has to be meaningful and add value. May Hermanus, the previous Chief Inspector, together with an external company, facilitate a four-day session. Preparation, understanding perspectives, and getting the decision makers to take part in the process must not be underestimated. The tangible and measurable elements for this process have been:

- ▶ The establishment of a quarterly steering committee for setting strategy and context
- ▶ The appointment of divisional safety representatives from organized labour to represent broad safety issues
- ▶ Integrating storytelling and revising induction and skills training
- ▶ Reviewing and implementing an effective safety representative reporting and functional system
- ▶ National labour leadership visiting operation shaft safety committees
- ▶ Joint investigation and agreed action planning through the risk management process

- ▶ The agreement that a white flag day is possible.

This has allowed an environment where the alliance was prepared to talk, share, celebrate and learn from failures and successes. It is trust such as this that creates a white flag day every day.

Conclusion

The safety journey that we are on has seen us shift our actual performance. I recognize all those managers, supervisors, workers, union representatives and inspectors who have believed that it could be done and who worked relentlessly to create a white flag day every day. Our work is not done yet. We have a long way to go, and the list of ‘millionaires’ achieved in this period is a tribute to you and recognition that a white flag day is possible. Remember that you can achieve anything in life as long as you do not mind who gets the credit. ◆

Table 1

Millionaires from June 2007

Mine	Fatality-free shifts	Date
Great Noligwa	1000 000	20 September 2007
Great Noligwa	1500 000	27 December 2007
Mponeng	1000 000	18 June 2008
Moab Khotsong	1000 000	21 July 2008
Great Noligwa	1000 000	25 September 2008
Kopanang	1000 000	10 November 2008
Moab Khotsong	1500 000	1 December 2008
Kopanang	1250 000	17 January 2009
Tau Lekoa	1000 000	3 February 2009
SA Division	1000 000	5 February 2009
Great Noliwa	1500 000	12 February 2009
Kopanang	1500 000	17 March 2009
SA Division	1000 000	10 July 2009
Great Noligwa	2000 000	16 July 2009
South Africa Devision Services	7000 000	12 September 2009
Kopanang	1000 000	17 October 2009
SA Division	1000 000	23 October 2009
SA Division	1000 000	11 December 2009
Kopanang	1000 000	15 January 2010
Maob Khotsong	1000 000	20 Jan 2010
SA Division	2000 000	5 February 2010
SA Division	2 691 272.76	3 March 2010
SA Metallurgy	11 000 000	1 April 2010