



## The discovery of asbestos at the USAR NSWB training site

### Managing organisational risk

*Protecting People, Property and the Environment*

## The trajectory – key decision points

- April 2004
  - 3000 tonnes of “clean” fill brought onto USAR to construct USAR prop for training
- September 2005
  - Asbestos like material first identified on surface of stockpiles; asbestos confirmed
- February 2006
  - Senior management becomes aware of potential health risk and enacts action plan for managing issue



## Active failures and latent conditions

- Organisational accidents different to individual accidents in genesis and impact
- Nothing accidental about the precursors
- Active failures describe the “how” but not the “why”
- Latent condition create windows of opportunity for active failures to penetrate defences

## Likelihood and consequence

- “Latent conditions can the **increase likelihood** of active failures through the creation of local factors creating errors and violations, and can also aggravate the **consequences** of unsafe acts/errors”
- *James Reason*

## From little things...

- “We know that single causes are rare, but we don’t know how small events can become chained together so that they result in a disastrous outcome. To anticipate and forestall disasters is to understand regularities in the ways small events can combine to have disproportionate large effects”
- *Karl Weick US social scientist*



## Active failures and latent conditions

"Clean" fill brought onto site without adequate clearance/documentation	Limited resources to construct prop combines with "can do" culture
	No formal procurement policy for "fill" or RA of environmental contaminants
	Unclear responsibility and accountability lines

## Active failure and latent conditions

Presence of asbestos identified	"Production pressures" to keep site going
Inadequate advice about health risk and scale of contamination	Internal communication failures delayed response
Poor understanding of potential health risk shaped local management	Lack of clarity of protocols for managing such an issue
	Failure to communicate to all stakeholders fuelled later escalation
	Underestimation of scale of impact and potential organisational risk





## Immediate management response

- Executive management team formed
- Regulators informed
- Internal investigation commenced
- Health and Welfare plan prepared
- Communication plan for all stakeholders prepared and implemented
- DDB Screening offered

## Costs and consequences

- \$\$\$ in legal fees and consultancies to manage issue and remediate
- WorkCover investigation
- Organisational reputation
- Loss of assets
- Stakeholder relationship damage
- Anxiety and stress for all involved

## Factors which aggravated consequences

- Extent of the potential exposure
- Nature of the exercises
- Public perceptions of asbestos risk
- Delay in communicating discovery to stakeholders
- Delays in communicating progress
- Internal investigation
- Local politics
- Media



## Initiatives

- Undertook ERA of all NSWFB training sites
- Developed structured RA approach to all external NSWFB training sites
- Asbestos registers of all NSWFB premises
- Reviewed operational SOGs and reporting protocols
- Tightened up Regulatory reporting protocols
- Established DDB screening for all NSWFB present and retired

## Learnings

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- Manage perceptions, appreciate context
- Communicate early and often
- Organisational risk
- Prepare a major incident plan and a management team ready to go
- Be proactive in identifying hazards and cautious in assessing risks
- Focus on the why not just the how
- Continually ask the what if?

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If the price of freedom is eternal vigilance,  
the price of safety is chronic organisational  
unease.