Anatomy of an Object Fall from Height Incident Awareness Program PARTICIPANT Manual

TK Elevators

v3.0 25 February 2024

Table of Contents

Welcome

Thank you for attending this workshop. It is hoped that this workshop will impact you in a couple of ways:

- Firstly, it will make you consider how you perceive your safety whilst working at heights and whilst working within elevator shafts with other people who you may or may not know (such as Contractors).
- Secondly, it will lift your skill in understanding about why and how incidents happen – so that incidents and near-misses can be successfully prevented.
- Lastly, it will help you appreciate what a safety culture is and how your actions can both immediately improve (or diminish) a safety culture and how a commitment to long-term planning can impact on the safety culture of every organisation that you work in for the rest of your life.

"I'm glad to see how young people are stepping up when it comes to safety. They are focussed on actively managing safety rather than being told to 'be safe'. It makes a difference - when people own things". Scott Cam, The Block.

"A great safety culture is when people continue to work safely and do the right thing, even when no one is watching". Anonymous.

Whether you are a Trainer or a Trainee, we look forward to supporting you throughout this Anatomy of an Object Fall from Height Incident Awareness Program.

Before we start, I wanted to share a bit of my own safety 'journey' and thoughts on safety. I want to impress on you just how important it is for me of the need for broader and deeper conversations across all TK Elevator job sites about incident prevention and of the need for all TK Elevator people to actively manage and "own" safety.

Many thanks,

David Husoy

Managing Director

Outcomes we are Aiming For

Attendance to this workshop is a requirement of an Enforceable Undertaking entered into by TK Elevator Australia Pty Ltd with WorkSafe Victoria in August 2023. The Enforceable Undertaking relates to an incident that occurred on 19 May 2020. The outcomes we are aiming for in this workshop are:

1. An awareness of the incident, the root cause and contributory factors of the incident and an analysis into why (existing) controls failed to prevent the incident from occurring.
2. Development of skills and knowledge in the Incident Cause Analysis Method (ICAM) and the 'Swiss Cheese' Model of incident causation.
3. Confidence in the TKE safety standards that are set and in the role that Trainees 'play' in managing, monitoring, and maintaining TKE safety standards for incident prevention and compliance.
4. Confidence in the role that Trainees 'play' in maturing the TKE organisational safety culture.
5. Personal growth via the development of an Individual Safety Culture Action Plan (SCAP).

What do you hope will be the impact of this workshop for you?

What might you hope to learn?

What might you hope to observe in others or have others observe about you?

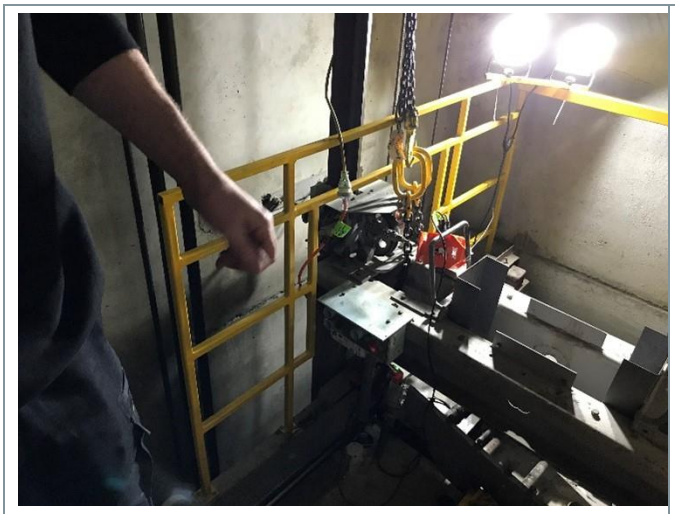
What would be a commitment for you to consider?

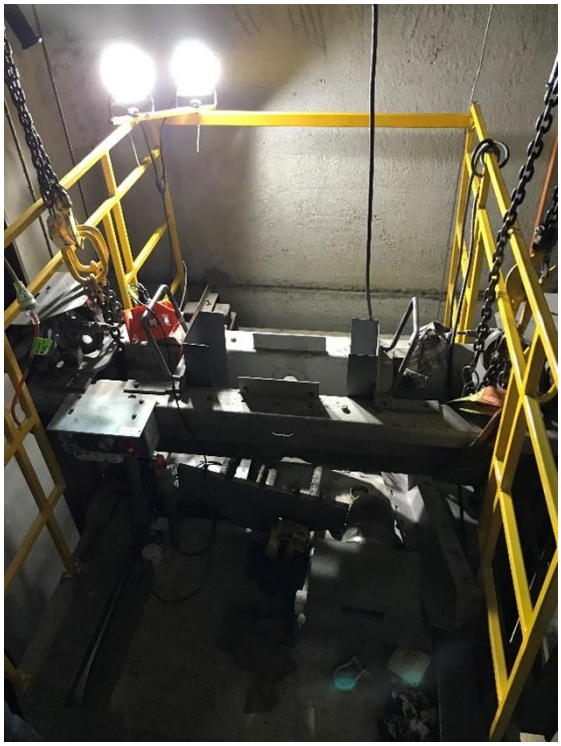
Case Study – Part 1

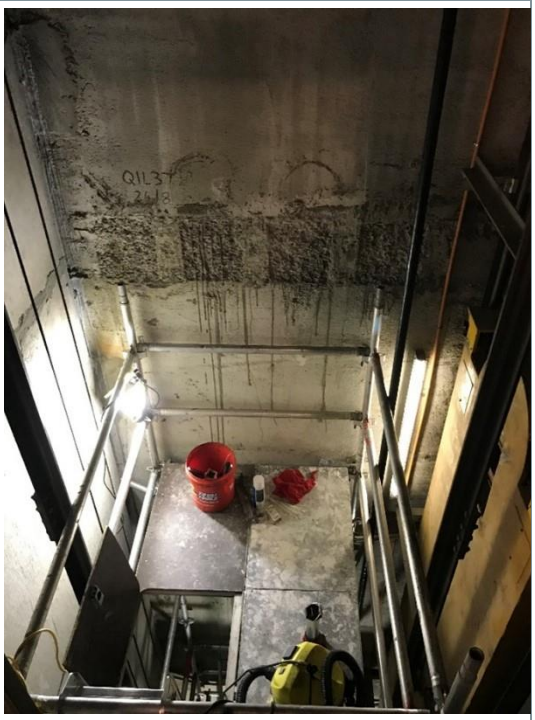
A subcontractor from Jim's Test and Tag was on top of an elevator car top with a TK Elevator employee (Employee 1) testing portable electrical equipment as part of annual test and tag requirements.

The subcontractor accidently knocked the testing / tagging machine (weighing approximately 2kgs) that was leaning on the handrail. The testing meter fell down the shaft (from level 13) hitting another TK Elevator employee (Employee 2) who was working in the lift shaft below them. The test machine scraped the employees back as it fell down the shaft and hit the back of his leg.

No medical attention was required, and the TK Elevator employee was able to resume his normal duties.







Small working group exercise

In groups of 3-4 people, discuss your responses to the following questions:

What happened?

What was the consequence?

What was the potential?

What is the first barrier that should have prevented the incident?

What is the next barrier that should have prevented the incident?

What is the next barrier that should have prevented the incident?

Case Study – Part 2

The subcontractor from Jim's Test and Tag was unfamiliar with working in a lift shaft and was not inducted to the hazards and risks of working at heights and objects falling from height. The subcontractor was on top of the lift car testing portable electrical equipment that was temporarily fixed / cable tied to the car top (the lift had full top of car handrails in place). A pre-start risk assessment and toolbox talk was completed by the team prior to the incident occurring but this did not include the subcontractor and was carried out prior to his arrival. The subcontractor was supervised by Employees on site however no additional pre-start / other risk assessment was completed by the Organisation prior to allowing access to the car top.

Testing and tagging electrical equipment whilst working at height and in the field was an unfamiliar task for all involved. Over previous years, testing had been conducted in the branch / warehouse which required the electrical equipment to be removed off site and bought into the warehouse for testing. A decision had been made by the organisation to arrange for the sub-contractor to test equipment in the field to minimise the impact on operations. A TK Elevator testing and tagging instruction had been issued regarding the testing and requesting that it was conducted in a 'safe' location, but this did not clearly stipulate to Field Employees the location or environment where testing was to be conducted on site.

In the process of supervising the subcontractor up to the car top, communication was temporarily lost between Employee 1 and Employee 2 about their whereabouts and position in the lift shaft. In more detail:

- On arrival, the sequence of work was discussed by the group (Employee 1 and 2 and the subcontractor) and it was agreed that testing would first be conducted in the basement / carpark and then followed by testing of equipment in the motor room and then on the car top. Testing then began on the equipment by the subcontractor in the basement / carpark with both Employee 1 and Employee 2 present.
- After completing this, Employee 1 advised Employee 2 that he would accompany the sub-contractor to test equipment located firstly in the motor room and then on the lift car top. Employee 2 remained in the carpark supervising the sub-contractor's vehicle which was double parked. Employee 1 and the sub-contractor then left and headed to the motor room.
- After completing testing in the motor room, Employee 1 and the sub-contractor then headed to test equipment on the top of the lift car which was positioned on the 13th floor as discussed and agreed to earlier.
- At about the same time, Employee 2 left the carpark and decided to go to level 1 and access the lift shaft to prepare for the removal of a counterweight sheave. It is assumed at this point, that Employee 2 thought that Employee 1 and the sub-contractor were still testing equipment in the motor room.
- Employee 1 (now on the car top) was not aware that Employee 2 had left the carpark and had moved to level 1 on the scaffold platform in the lift shaft.
- Employee 2 did not 'hear' the testing meter as it fell down the shaft nor any other emergency instructions from Employee 1 and the subcontractor as they assumed that Employee 2 was still in the basement / carpark.
- There was no signage on either the top or the bottom of the shaft where work was taking place.

TK Elevator Safe Work Procedures (SWP's) and Contractor Management Procedures outline how work is conducted in the field including high-risk work and the processes for managing sub-contractors. In general and in most circumstances, working above or below other persons in the lift shaft should never occur and only subcontractors directly involved in the servicing, modernization, repair, or installation of elevator equipment should work in operational areas including the lift shaft, pit, top of car and motor room. In this case, a SWMS which addressed the hazards of working at height was not prepared, a pre-start risk assessment was not conducted prior to work starting and the sub-contractor was not trained in TKE's SWP's.

Small working group exercise

In groups of 3-4 people, discuss your responses to the following questions:

What barriers / precautions should have been in place to prevent this incident?

What barriers / precautions could have minimised the damage / harm?

What factors contributed to the incident occurring? Think about this from the perspective of both the organisational / system processes and the employees involved (Employee 1, Employee 2 and the sub-contractor).

Reflection

Rate where you spend most of your time within the small working group exercise (1 is the most time compared with 5 which is the least time).

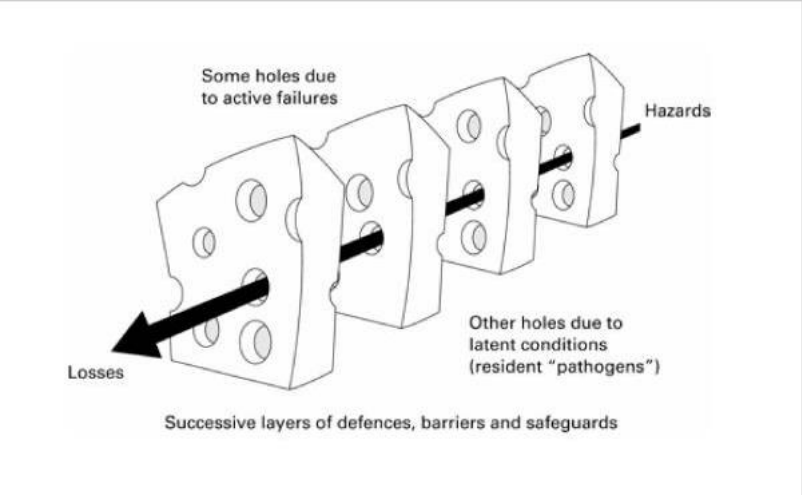
#	Where did you spend your time during this exercise?	Rating
1	Sharing your own personal / past experiences of incidents and near-misses like this incident.	
2	Blaming the Contractor or the Employees – they should have all known better!	
3	Can accidents / incidents be ever truly prevented? They just happen and no matter what steps we take they will always be a part of working in a high-risk environment.	
4	There are a lot of opportunities for improvement here and TK Elevators could have been much more proactive in preventing this incident.	
5	There are a lot of opportunities for reflection here – it could have happened to anyone (including me or my teammate).	
6	We had other reflections actually…	

Incident Cause Analysis Method (ICAM) and the ‘Swiss Cheese’ Model of Incident Causation

Over 20 years ago, James Reason proposed the image of “swiss cheese” to explain the occurrence of systems failures such as medical mishaps.

According to the metaphor, in a complex system, hazards are prevented from causing human losses by a series of barriers. Each barrier has unintended weaknesses or holes (hence the similarity with ‘swiss cheese’) and these weaknesses / holes are inconstant (that is, they open and close at random).

When by chance all holes are aligned, the hazard reaches a person and causes harm as per below:



The ‘swiss cheese’ model is widely accepted by WHS professionals and has formed the basis of the Incident Causation Analysis Method (ICAM) method of Incident Causation.

The ICAM process is an WHS analysis tool that ‘sorts’ the findings of an incident into a structured investigation framework. An ICAM investigation clarifies WHY an incident actually happened and identifies all of the factors that contributed to an incident occurring.

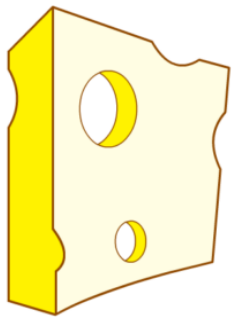
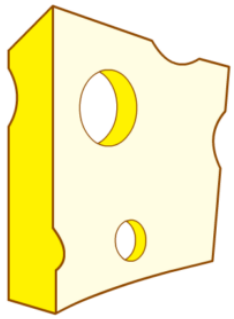
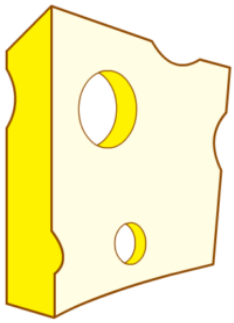
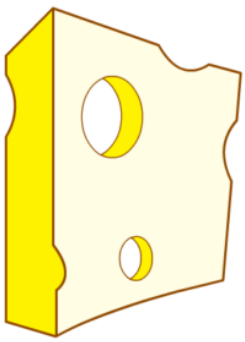
The ICAM process is intended to assist in identifying and developing recommendations to prevent a ‘repeat’ of an incident and to form the key learnings of an incident or “what did we learn that we can share”.

The ICAM process is often ‘informed’ by key learnings of past incidents. As a result, key organisational documents are available to assist. Let’s take each of these in turn:

Applying the Swiss Cheese Model to TK Elevator & This Incident

Small working group exercise

In groups of 3-4 people, complete the following:

	Barrier / Defence within TK Elevator that could have prevented this incident.
	Errors or Issues that impact on delivery of above defence
	Barrier / Defence within TK Elevator that could have prevented this incident.
	Errors or Issues that impact on delivery of above defence
	Barrier / Defence within TK Elevator that could have prevented this incident.
	Errors or Issues that impact on delivery of above defence
	Barrier / Defence within TK Elevator that could have prevented this incident.
	Errors or Issues that impact on delivery of above defence

TKE 10 Safety Rules

Lock Out - Tag Out (LOTO)

Always Test & verify

- Ensure there are no passengers in the cab.
- All doors are closed and mechanically locked.
- Guard any circuit that may not be deenergized on a locked out controller: eg.240V lighting. Always have the unit personally locked before working on the unit if it is not to be moved.

Fall Protection

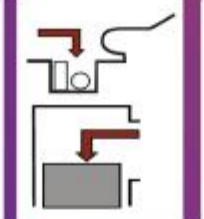
When a fall hazard exists conduct a risk assessment

- Always use proper work attire.
- Inspect your equipment before each use.
- Always be aware of your surroundings.

Car Top And Pit Access

Maintain control of elevator at all times

- Access: Car top – Send the car up down, open the door (Door-Lock) and fix the door stopper. Verify door safety, stop switches and inspection switch independently. Pit - Activate pit stop switch and use ladder safely.
- Egress: ensure stop switches are activated when exiting car top or pit. Pit – Deactivate stop switch(es) and use ladder or step aids safely.



Live Electrical/Troubleshooting

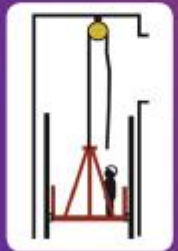
Use certified tools and prevent incidental contact with live electrical circuits. Probe with only one hand

- Lock out and tag out if power is not required. Inspect tools before use.
- Always guard live circuits. Test metre on a known source before use.

False Cars & Running Platforms

Operate with two means of safety

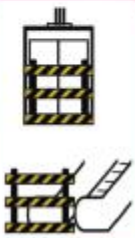
- Always use safeties and governor if hoisting with original machine.
- When using a temporary cable climbing hoist a secondary Blockstop is required.
- Governor and/or safety foot pedal is required.



Barricading

Secure workplace properly with barricades

- When swing doors, automatic doors , steps, step-treads, pallets, comb-plates, comb-plate teeth, floor plates or trap doors, have been removed or have not been installed leaving an open fall hazard, the unit has be secured with barriers (for escalators in both ends). Barricades are to be secured to the unit when work is not being performed in the area.



Jumpers

Always count jumpers before and after use

- Inspect jumpers for damage. Only use approved jumpers.
- Jumpers may not be installed on the safety circuit when the elevator is on automatic operation.
- Always notify co-workers when jumpers are being used.

PPE

Always wear proper personal protective equipment

- Always wear proper work attire and if necessary: safety shoes, helmet, eye protection, hearing protection and protective gloves.
- Safety glasses must be worn on all sites.

Mechanical Stored Energy

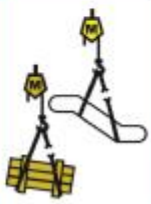
Avoid pinch point of materials & tools

- Avoid loose clothing and be careful when wearing gloves near moving machinery.
- Ensure all loads are stable and secure.
- Avoid the red zones (leaning over to adjacent shaft ect.)

Rigging & Hoisting

Verify stability & capacity

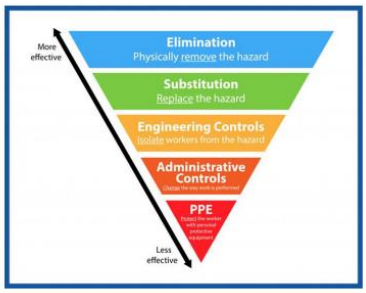
- Inspect rigging equipment before each use. Ensure load slings are properly sized.
- Ensure load will clear all obstructions.
- Do not stand or walk under load being hoisted.
- Only conducted by certified rigger.



OBJECT FALL FROM HEIGHT RISK

How do we reduce the Risk?

- Each Falling Object incident and near miss experienced is a potential fatality or serious injury.
- A pre-start risk assessment should always be conducted prior to beginning work.
- When considering effective controls to avoid an Object Fall from Height incident, your attention is drawn to the Hierarchy of Control.



- **ELIMINATION -** eliminate the hazard by avoiding (where possible) any work that occurs above and below each other.
- Where this is not practical, implement other controls by **SUBSTITUTING** or replacing the hazard with another method or location of work or with **ENGINEERING** controls such as hard barriers or shields or lanyards or tethers that isolate workers from any overhead risk or stop objects from falling.
- Implement other **ADMINISTRATIVE** controls such as warning signage, safe work procedures or scheduling of work.
- As a last resort and to provide some personal protection, use **PPE** such as hard hats where there is a risk of any objects falling from above.

OBJECT FALL FROM HEIGHT RISK – REDUCING THE RISK

If work above and below each other or the potential for Falling Objects cannot be eliminated.

- Ensure that work platforms, landings, tops of cars etc have edge protection or toe guards.

- Store equipment / materials in the middle of the car roof. Never store equipment on the edge of the landing or within the confines of shaft hoarding and cages.

- Ensure that penetrations into the lift shaft or from the motor room floor are protected.

- Implement temporary shaft screening to protect workers in the lift shaft especially in common / adjacent lift shafts. Provide side protection in open atrium areas.

OBJECT FALL FROM HEIGHT RISK – REDUCING THE RISK

If work above and below each other or the potential for Falling Objects cannot be eliminated.

- Use "Danger" or "Warning" signage to warn others above or below if working in the pit or in the lift shaft above.

- Implement exclusion zones with barricades. Ensure that hoardings and cages are lockable or secure to prevent unauthorised access to the lift shaft.




- Ensure that lifting activities are conducted by people with the appropriate HRW (High-Risk Work) licence.
- Test and ensure lifting equipment is certified.
- Ensure that SWL limits are not exceeded.
- Develop a lift plan for complex lifting activities.



- Tether tools or equipment on the top of the elevator car or within the lift shaft with lanyards or cable ties to stop them from falling.


Reflection:

- Discuss with the group your understanding of the TKE GSM Induction and 10 Safety Rules.
- Using the principals of the 'swiss cheese' model, consider what Health and Safety Rules, if implemented, could have prevented the incident from occurring. Why?

Extract from TKE ANZ OHS Procedure Manual

12.5 RISK-BASED APPROACH

As outlined in the "Introduction" section of this procedure, TKE adopts a risk-based approach in the management of contractors and sub-contractors. This means that all, some or none of the requirements or processes outlined in this procedure may be required to be implemented. This will depend on the type of contractor or sub-contractor engaged, the type of work activity they will perform and whether the work is occurring on or at a TKE facility (contractor) or at a customer location or project site (sub-contractor). Contractors and sub-contractors are classified as either:

High Risk: engaged to perform "core" activities on behalf of TKE including the manufacturing, installation, modernization, service, and repair of TKE or non-TKE products and units in TKE's portfolio. High-risk work may also involve non-core work but be high-risk in nature and have the potential for SIF (Serious Injury or Fatality) incidents to occur e.g. transporting heavy equipment or machinery, cranage etc.

Medium Risk: engaged to perform "core" activities on behalf of TKE including the manufacturing, installation, modernization, service, and repair of TKE or non-TKE products and units in TKE's portfolio but the work activity is being performed in medium-risk locations and environments. For example a sub-contractor engaged to deliver supplies and equipment to a customer site or a sub-contractor working on a car interior or building floor or landing i.e. they are not working in the lift shaft, lift pit or motor room and are not exposed to any high-risk work such as work at heights or electrical work.

Low Risk: Contractors and sub-contractors who are not performing work categorised as a "core activity" or other contractors engaged to work at TKE facilities in non-operational, administrative or supportive functions.

12.6.2 Preparation for Works

Prior to site attendance and the beginning of works this includes:

- The contractor or sub-Contractor undergoing any internal training by TKE in its SWP's (Safe Work Procedures) and GSM (Global Safety Manual) Induction Training.
- The preparation by the contractor / sub-contractor of any applicable SWMS (Safe Work Method Statements) for high-risk construction work (as defined in applicable WHS legislation) and a review and approval of this by a TKE representative prior to work commencing.

TKE Elevator Contractor Management Procedures

Extract from TKE ANZ OHS Procedure Manual

Note: The completion of these steps will depend on the type of contractor / sub-contractor engaged, the type of work activity they have been engaged to perform and the location that this work activity will occur at.

12.6.3 Site Commencement

On arrival or commencement at a TKE facility or a Customer site or project this will involve:

- Completion of any site induction or training (either provided by TKE or the Customer representatives).
- A review of any applicable work activity SWMS and these being signed by the contractor / sub-contractor team or personnel to indicate that these have been reviewed.
- Conducting any further project or work activity pre-start risk assessment and toolbox talk with the Contractor / Sub-Contractor team or personnel prior to work actually starting.

Note: The completion of these steps will depend on the type of contractor / sub-contractor engaged, the type of work activity they have been engaged to perform and the location that this work activity will occur at.

Reflection:

- Discuss with the group your understanding of the TKE Contractor Management Procedures.
- Using the principals of the ‘swiss cheese’ model, consider what parts of the Contractor Management Procedures, if implemented, could have prevented the incident from occurring. Why?

SWP08 – Work at Height

The following hazards exist:

- A person falling from height; and
- An object falling from height that may strike a person or object below.

6.10 Risk Controls to Manage Falling Objects when Working at Height

The controls to manage the risk of falling objects from a height are similar to those that manage a person fall from height. If the work at height cannot be eliminated, then controls such as isolation and restraint are often effective in managing the risk of falling objects. Examples include:

- **Toe guards and kick boards** to prevent objects being dropped or kicked over edges (used on scaffolding and on the edges of elevator car tops);

- **Hard barriers** such as hole or hatchway covers;
- **Safety netting and mesh**;

- **Tool lanyards** – lines connected to a fixed point and attached to tools being used at height that will prevent them from falling if dropped;

SWP08 – Work at Height

- The use of isolation such as **exclusion and "no go" zones** in areas below where work is taking place overhead (no work should occur in the shaft or pit if working is taking place above);

- **Warning signage** to highlight the risks of entry to an area where there is an unguarded fall hazard, or to areas where work is being undertaken overhead and there is a risk of falling material; and

- **Administrative controls such as SWP's and SWMS** where personnel are instructed not to store equipment or tools near unprotected edges such as on landing floors, open areas to elevator shafts or the tops of elevators cars.

- **PPE or Personal Protective Equipment** – PPE is the lowest and most ineffective form of risk control. While individual equipment such as life-lines, restraints, harnesses, shock absorbing lanyards etc can also be classed as personal protective equipment, in this procedure this equipment is categorised as work positioning and fall protection equipment. PPE in relation to the management of falling objects includes hard hats and helmets that can provide protection to people from falling objects.

The following hazards exist with Working on Top of a Lift Car:

- Falling from height down the lift shaft from the side of the top of the lift car or falling when climbing across the bow to access the rear of the lift car roof.
- Being struck by objects falling down the lift shaft from the top of the lift car.
- Whole body or part of body crush injuries when getting caught between the lift car and stationary objects or between the counterweight and stationary objects or between the top of the lift car and the shaft overhead when the lift is moved.
- Being struck by lift cars in adjacent lift shafts.
- The lift moving unexpectedly and getting hands, arms and other body parts entangled or caught in moving parts and machinery such as moving sheaves and nip points on door operator pulleys.
- Entanglement of personal fall protection equipment if the lift moves unexpectedly.
- Electric shock.

4.2 Competent Person / Assessment of Competency

A competent person is someone who has acquired through training, qualification or experience the knowledge and necessary skills to carry out a task or in this case work on top of a lift car. Assessment of competency is a structured process involving the identification and evaluation of an individual's performance against a set of defined behaviours and processes as outlined in this SWP required to complete the task or job effectively and safely. Ensuring competency involves the delivery of information, instruction and training in a combination of both theoretical and practical (on-the-job) environments. Demonstrating competence involves physically Working on Top of a Lift Car under the supervision and instruction of a competent person and is a combination of both practical and theoretical knowledge, cognitive skills, behaviour and values to ensure performance and is a state of being adequately qualified or having the ability to perform a specific role or task. Working on Top of a Lift Car Competency Assessment as outlined in section 8.1 must be completed before a person operates this equipment.

7. WORKING ABOVE AND BELOW EACH OTHER (ELEVATOR PIT, SHAFT OR TOP OF ELEVATOR CAR)

In most circumstances, work should never occur in the lift shaft, top of car or pit when there is someone working above and below. In general: Never allow anyone to work below in the lift shaft or in the elevator pit while someone is working in the shaft or from the car top above. If people are working in the shaft or pit, then access to the top of car or further up in the shaft is to be restricted and secured to prevent access. If people are working on the top of the car or in shaft above, then access to the pit or the bottom of the shaft is to be restricted and secured to prevent access. Use warning signage to warn other workers when work is taking place above on the car top or below in the shaft or pit.

There may be occasions where Technicians do need to work above and below each other in the lift shaft. For example, when load weighing, inspecting safety gear and adjusting roller guides. In this situation, risk controls should be implemented to reduce the risk of objects falling from height and to control any unintended movement of the elevator towards the Technician(s) working below. For this type of activity:

- Always conduct a pre-start risk assessment;
- Always control the movement of the elevator car (must always be on inspection or hand control and never on automatic); and

Always maintain verbal communication between the Technicians involved (by voice if in the lift shaft or by other means or communication devices if the elevator car is being controlled from another location).

9. TRAINING / QUALIFICATIONS

9.1 General

In general, only trained, licenced and trade-qualified elevator technicians should work on top of elevator cars. Other non-operational TK Elevator personnel (in other functional roles) who need to access the elevator shaft or top of car for inspections or site visits must always be directly supervised by a competent person or licenced and trade-qualified technician (refer to separate TK Elevator policy on "Non-Operational Personnel Accessing Elevator Environments" for further information) when accessing the lift shaft or top of elevator car.

9.2 Contractors Working in Lift Shafts and on Top of Elevator Cars

Only TK Elevator approved sub-contractors whose work requires them to be in the elevator shaft or on top of the elevator car (their work involves the installation, modernisation, upgrade, repair, maintenance or servicing of elevators) should access the elevator car top. Other sub-contractors whose work does not require them to be in this area (on top of the elevator car) must never be provided access to the car top or the lift shaft if not required and essential for the work they are engaged to perform.

9.3 SWP Training

TK Elevator employees and approved sub-contractors need to be trained in this SWP (review the information contained in this document) and have their competency assessed to demonstrate that they can work on top of the elevator car safely. The person who assesses the worker's competency must themselves be deemed competent or someone who has acquired through training, qualification or experience the knowledge and necessary skills (see sections 4.1 and 4.2) to perform this work safely and effectively. Assessment competency in this SWP is to be assessed using the "SWP 10 - Working on Top of a Lift Car – Verification of Competency Assessment" (Ref: HSEQ-FRM-SF44).

Reflection:

- Discuss with the group your understanding of TKE Safe Work Procedures.
- Using the principals of the 'swiss cheese' model, consider what elements of the TKE SWP's, if implemented, could have prevented the incident from occurring. Why?

The Powerful 6 Questions

What are the Powerful 6 Questions?

The Powerful 6 Questions Support the TK Elevator Global Safety Standards and the TKE Vision of all TK Elevator people actively managing and “owning” safety.

The Powerful 6 Questions align to you and your role at TKE.

Small working group exercise

In groups of 3-4 people, discuss your responses to the following questions:

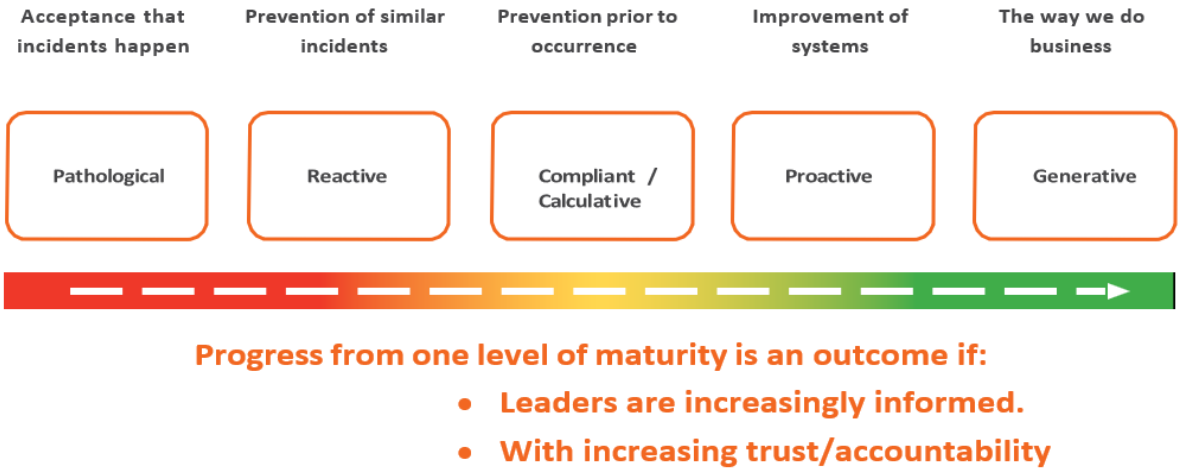
#	Powerful Question	Powerful Response
1	What am I accountable for?	
2	What are the key hazards and risks in my area of accountability?	
3	How do I go about maintaining a clear picture of the key risks in my area of accountability?	
4	What critical controls can be used to ‘manage’ these risks, by eliminating them and if not reasonably practicable to do so, by controlling them?	
5	How do I know these controls are actually in place?	
6	How do I know these controls are effective in managing the risks?	

Maturing a Safety Culture

As TKE Employees, we make an impact on the organisational safety culture or “the way we do things around here”. We influence the safe behaviours of the team and of the subcontractors that we work with and alongside.

As TKE Employees we aim to produce safety and wellbeing outcomes that change the quality and the effectiveness of TKE and, if done well, will lead to more satisfied customers and an increase in the strength of our brand and reputation across the Construction Industry.

Explaining Organizational safety culture is best explained by sharing the Hudson Safety Culture Maturity Model:



“What costs money is not safety, but bad safety management. Once the management of an organisation realises that safety is financially rewarding and that the costs incurred must be an investment on a positive return, the road to a ‘full’ safety culture is open.” Professor Patrick Hudson, 2001.

Reflection:

Rate where you believe you, your team and your organisation ‘are’ currently to the Hudson Safety Culture Maturity Model. Using your knowledge of ICAM – consider:

- Why? What can be done about it?
- What can we learn and what can we share to ‘move up’ the Safety Culture Maturity Model over time?

Individual Safety Culture Action Plan

Personal growth is often realised by establishing a proactive Individual Safety Culture Action Plan (SCAP).

But first what attitudes, values and beliefs exist for you?

As a Leader / Supervisor	As an Employee?	As a person?

Our Concrete, Next Steps

Our agreed concrete next steps are:

1.

2.

3.

Feedback Form

Thank you for attending this workshop. It is hoped that this workshop will impact you in a couple of ways:

- Firstly, it will make you consider how you perceive your safety whilst working at heights and whilst working within elevator shafts with other people who you may or may not know (such as Contractors).
- Secondly, it will lift your skill in understanding about why and how incidents happen – so that incidents and near-misses can be successfully prevented.
- Lastly, it will help you appreciate what a safety culture is and how your actions can both immediately improve (or diminish) a safety culture and how a commitment to long-term planning can impact on the safety culture of every organisation that you work in for the rest of your life.

Please complete the Feedback Form before you leave: