



Safety Business Report – January to February 2021

Contents

1. Recommendation	2
2. Executive Summary	3
3. Key Matters	4
4. Organisation	11
5. Performance.....	17
6. Monitoring and Assurance.....	19
Appendix – DIDP Lessons Learned.....	21



1. Recommendation

That the Board:

- Note the Safety report for Auckland Transport (AT) for January to February 2021.
- Note the Board-level deep dive into the Vulnerable Road User matter and the Road Safety Business Improvement Review update and validation to be provided at the next Board meeting.

Prepared by: AT Safety Team

Endorsed by: Bryan Sherritt, Executive General Manager Safety

1.1 Strategic Alignment

AUAHATANGA <i>Better, Bolder, Together</i>	<i>This report details business-wide actions, and Key Performance Indicators to assist the board in meeting their due diligence obligations.</i>
MANAAKITANGA <i>We Care ... Full Stop</i>	<i>This report demonstrates integrity associated with meeting ethical and legal obligations.</i>
TIAKITANGA <i>Safe with us</i>	<i>This report comments on the work our people are undertaking and the Critical H&S Risk areas facing AT, including the work being done to address these.</i>
WHANAUNGATANGA <i>We Connect</i>	<i>This report details workplace safety audit results and reports findings and updates to the Executive Leadership Team and Board.</i>



2. Executive Summary

This report provides an overview of AT's safety matters for the period January to February 2021. There were four notifications to NZ regulators during this reporting period, two each in January and February. There were nine road deaths recorded on Tāmaki Makaurau Local Roads and State Highways from 1 January to end of February 2021, two more than the five-year average and five more than in 2020 for the same period. Combined with the 11 road deaths in November and December 2020, the numbers are significant and require a real focus on leadership, policy and partnerships which have been central to AT's recent discussions over the increasing number of road trauma related deaths with NZ Police and Waka Kotahi.

Vulnerable Road Users (VRU) continues to remain a significant matter and continues to be an upward trend. Deaths of motorcyclists is higher than the previous year and the five-year average and makes up 33% of all deaths in Auckland which is 15% higher than the proportion of motorcycle deaths nationally. A review into the VRU context, risks and controls has been undertaken. The interim results of the VRU investigation have found that there is very significant under-reporting of serious injuries of people walking, cycling and on other transport devices in the Ministry of Transport Crash Analysis System (CAS) when compared to Ministry of Health hospitalisation data. The VRU deep dive is proposed for May Board.

Eric Howard is in the final stages of undertaking a review of the progress made on the recommendations in the 2018 Road Safety Business Improvement review (BIR) and will highlight areas of collective focus to lift the road safety performance in Tāmaki Makaurau. Interviews have been conducted with key partners, including leaders from Waka Kotahi, NZ Police and Ministry of Transport (MoT) to provide their perspective into the report. The final draft report will be submitted in April to AT Safety Team and will be shared with the AT Board in May.

The Safety Team are initiating the process of developing a Safety Strategy which will outline a clear safety intent and direction including goals and targets for AT and our contractors. The development of this strategy will enable AT to deliver measurable improvements in safety performance which further enhances its reputation, further reduces harm to people, customers, communities and assets, engages staff and improves overall performance. The Safety team are planning to prepare a series of further deep dives for the Board to provide insight and research into key priority areas across AT's span of responsibility and to align with early conversations with the BIR update and validation. These deep dives include a focus on police enforcement, vulnerable road users and safety policy and regulatory settings.

The Downtown Infrastructure Development Project (DIDP) continues to make the adjustment to a revised critical risk and verification regime. There has been significant engagement during this reporting period to build on the recommendations made in the recent external reviews and the increased focus upon verification is welcome. Our focus now targets the assurance regime and increasing the layers of assurance activity.

AT's existing Synergi - H&S Incident Management and Reporting tool is currently being upgraded to the latest version which will remove the current impediments around usage and adoption of the tool across AT employees and external partners. The software upgrade is now expected to complete User Acceptance Testing (UAT) end of April.



3. Key Matters

This section aims to ensure that specific and significant changes in health and safety matters and material risk are set out to the Board. This section also presents matters which represents further opportunity to provide sector and regional leadership opportunity for the Board at the strategic level.

The proposed matters for this reporting period are:

- Auckland fatality overview for the current reporting period – January and February 2021
- Board deep dives into current and emerging risk across AT's span of responsibility including VRU update
- Health and Safety Case Management System
- Downtown Infrastructure Development Programme (DIDP) update

3.1 Auckland Fatalities Overview for January and February

There were nine road deaths recorded on Tāmaki Makaurau Local Roads and State Highways from 1 January to end of February 2021, two more than the five-year average and five more than in 2020 for the same period.

January road deaths

Tāmaki Makaurau recorded two road deaths in the month of January. Both were killed on AT local urban roads. A 32-year-old male passenger travelling in a stolen vehicle with four other occupants. All occupants in this vehicle were wearing restraints including the deceased. The vehicle had been travelling at an estimated speed of about 80km/h where it lost control when rounding a moderate bend with a 45km/h advisory speed and rolled.

The other was an 88-year-old male who had crossed a two-lane residential street to the painted medium strip. Whilst waiting on the painted medium strip he was struck by a vehicle that had pulled out of a driveway turning right onto the painted medium strip with the intention to merge into traffic.

February road deaths

In February, Tāmaki Makaurau recorded seven road deaths. The highest number of deaths recorded for the month of February since the year 2005 which had eight. Details of the fatalities are:

- Four of those killed died on AT urban and open roads, a 35-year-old male driver and three motorcyclists aged between 32 and 61 years old.
- The other three people were killed on open state highways. Two female drivers aged 68 and 73 years of age from separate crashes and a male passenger aged 71 years old. It was reported that all four vehicle occupants wore restraints.



All four vehicle occupants and a motorcyclist were involved in loss of control / head on crashes and the other two motorcyclists were involved in crossing/turning type crashes. In one incident a driver turned right into a driveway into the path of the motorcyclist travelling straight through on a road with a 80 km/h speed limit. In the other incident at a location undergoing roadworks with a 40km/h temporary speed limit a driver turned right at the intersection into the path of the oncoming motorcyclist.

A January and February performance summary is included in the Performance Section 5.

Current insights into DSI in Tāmaki Makaurau

On the following page is a figure looking at the contributing factors towards the likelihood and the severity of crashes. Figure 1 shows that speed and alcohol and drugs are the predominant causes of crashes in Tāmaki Makaurau. By reducing the speed limit by 5km/h in Tāmaki Makaurau it can save over 50 lives and serious injuries over a year. It shows that more than 82% of rural roads and 59% of urban roads are currently not at safe and appropriate speed limits. This emphasises the need to continue implementation of speed management and the setting of the speed limits rule by Waka Kotahi. The data and findings highlighted in Figure 1 creates a bigger picture of the cause and key areas for future safety deep dives which are identified in Section 3.2 below.

Some key pieces of work that AT and the Safety Team are currently undertaking in response to this includes:

- AT's Chief Executive's correspondence with Police Commissioner Coster from the New Zealand Police and Nicole Rosie, Chief Executive of Waka Kotahi NZ Transport Agency outlining AT's concern over the increasing number of DSI's since Auckland's second Covid-19 lockdown (discussed in later section).
- Tāmaki Makaurau Mayor Phil Goff's correspondence with Minister of Police, Hon Poto Williams and Minister of Transport, Hon Michael Wood supporting AT's request to lift enforcement efforts across Tāmaki Makaurau to achieve our efforts to achieve Vision Zero.
- Eric Howard's road safety BIR review.
- Leadership and advocacy work at the Tāmaki Makaurau Governance Group led by Bryan Sherritt.
- March 2021 Planning Committee presentation seeking support from the Mayor and Councillors on recent Vision Zero performance and road safety programme actions.



Causes of road deaths and serious injuries in Tāmaki Makaurau

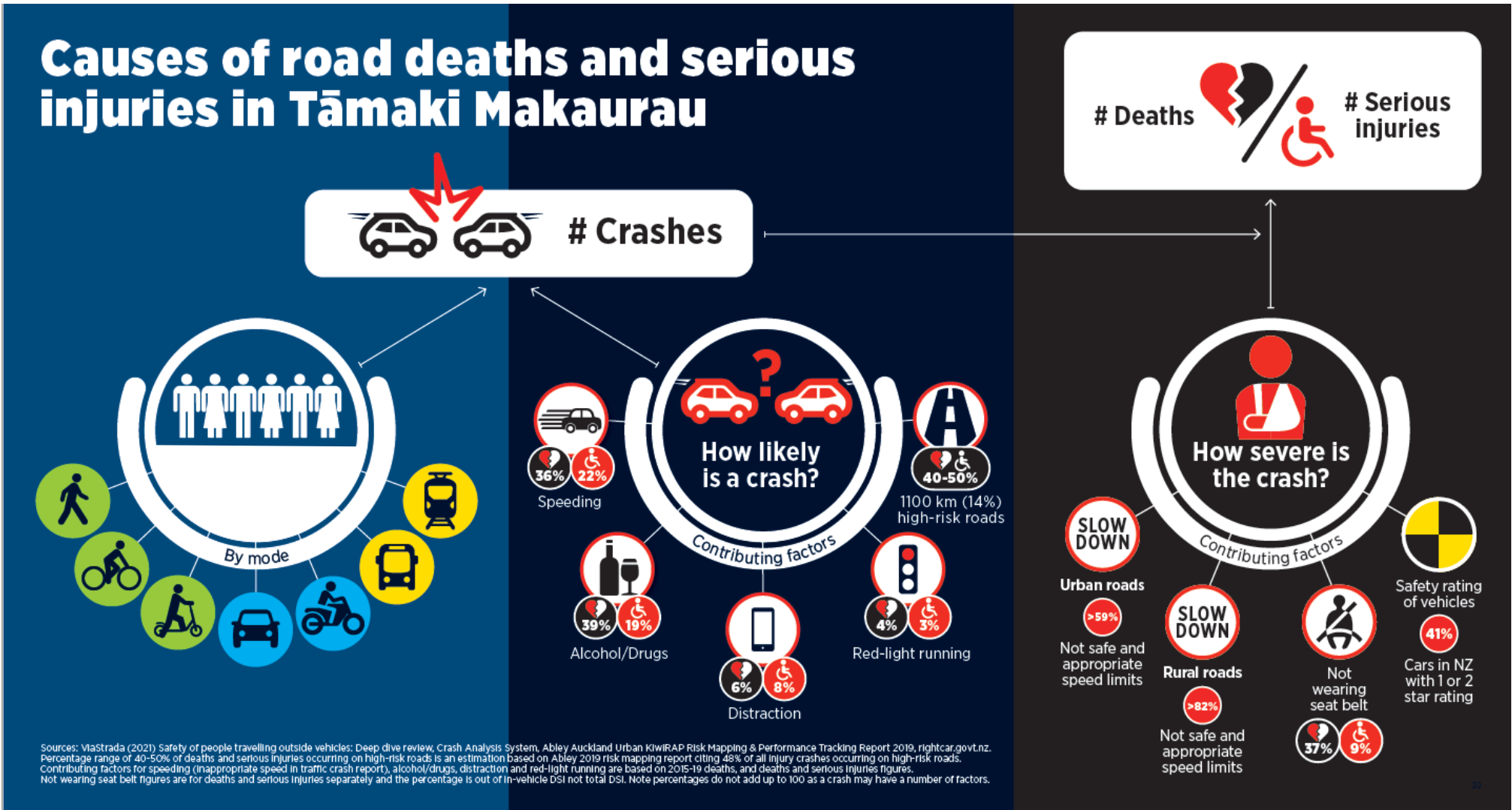


Figure 1 – Causes of road deaths and serious injuries in Tāmaki Makaurau



External Partnerships

The Tāmaki Makaurau Governance Group was held on the 11th of February 2021. The group received an update from the MoT on their policy and regulatory actions from the Road to Zero Strategy. Waka Kotahi presented the Auckland results from their road perceptions survey which are being used in an advocacy effort to improve enforcement and accelerate regulatory reviews. The police outlined changes made at Police HQ to ensure greater focus on road policing. The Governance Group advocated for the demerits for camera offences to be included in the review of financial penalties that is due to begin in April.

An important note to add although not in the current reporting period.

At the February 2021 Board meeting, the AT Board and CEO agreed that further leadership and advocacy was needed from AT to ensure all parts of the system are working together to achieve the goals in the Vision Zero for Tāmaki Makaurau Road Safety Strategy and Action Plan. As a result of this discussion, on the 22nd of March 2021, Shane Ellison sent a letter to Police Commissioner Coster from the New Zealand Police and Nicole Rosie, Chief Executive of Waka Kotahi NZ Transport Agency. The letter outlined AT's concern over the increasing number of DSI's since Auckland's second Covid-19 lockdown and the causes based on recent data. The data highlighted that alcohol and drugs and speed remain the predominant causes of road trauma in Tāmaki Makaurau. The letter raised the concern that the NZ Police data highlighted the lack of police deterrence, especially with respect to roadside breath testing. Waka Kotahi's survey of perceptions of road safety identified that only 30% of Auckland drivers had been stopped by an alcohol checkpoint in the past 12 months (completed March 2020). This is a significant decrease from 55% in 2013. The letter also noted that the level of roadside breath testing has dropped regionally as well as nationally from three million tests per year in 2013/14 to an estimated 1.6 million in 2019/20. Over the past five years in Tāmaki Makaurau, there has been an upward trend in the number of infringements through static or fixed location cameras but a drop in mobile enforcement which contrasts with the general deterrence model referenced in the national Road to Zero action plan and misaligned with international best practice speed enforcement. The letter highlighted some key topics to discuss with NZ Police and Waka Kotahi in April including:

- The viewpoint from NZ Police and Waka Kotahi in respect of the current approach and respect of general deterrence in Tāmaki Makaurau
- The opportunity for Auckland Transport to review the 2021-2023 Road Safety Partnership, including regional outcomes and measures for Tāmaki Makaurau
- A commitment to regular reporting on road policing activities to the AT Board and Tāmaki Makaurau Transport Safety Governance Group
- An increase in the number of roadside breath test and mobile deterrence activities in the fourth quarter of this financial year and ongoing
- Support in advocating for the fast tracking of the review of financial penalties signalled in the Road to Zero action plan and for this review to include the addition of demerit points to camera issued fines.



3.2 Board deep dives into current and emerging risk across AT’s span of responsibility

VRU Deep Dive

The AT Board requested a deep dive into the safety of people travelling outside vehicles at the December 2020 board meeting. Phase One focused on understanding the size, nature and causes of the problem and has been completed. The Board will be presented with these findings at the May Board meeting. The interim high-level key findings are:

- There is very significant under-reporting of serious injuries of people walking, cycling and on other transport devices in the Ministry of Transport (MOT) Crash Analysis System (CAS) which is the primary source of road safety data.

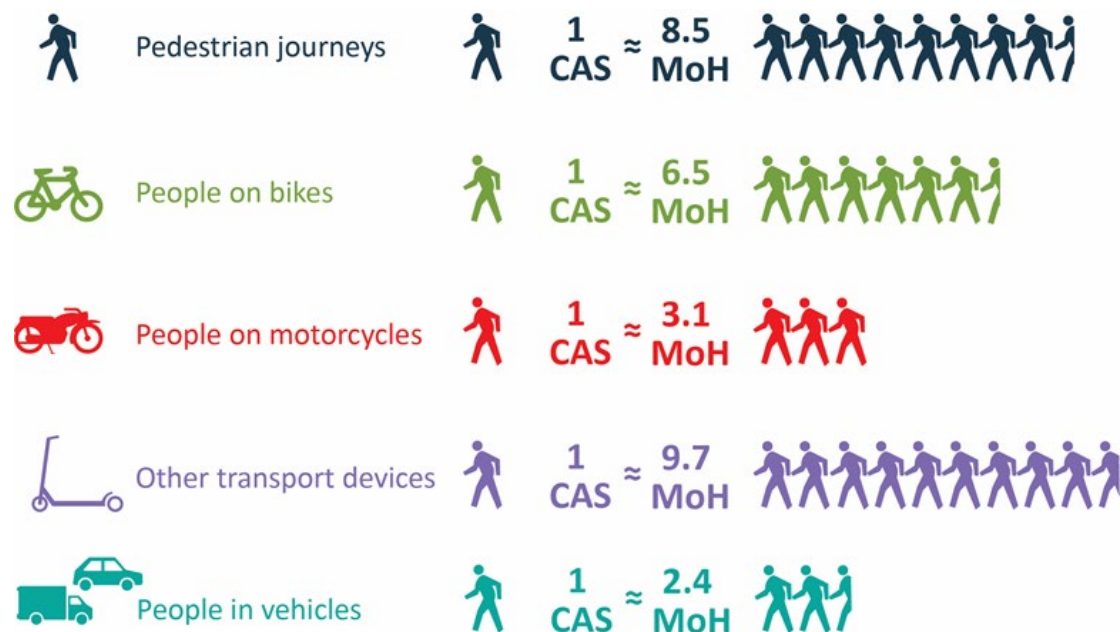


Figure 2 - Comparison of the number of serious injuries in Ministry of Health (MoH) data compared to MoT Crash Analysis System (CAS) data

- Ministry of Health (MoH) hospitalisation data shows from 2016-2019, 66% of serious injuries (defined as at least one night in hospital) were from people travelling outside vehicles. In comparison, Ministry of Transport Crash Analysis System data shows 46% of serious injuries were from people travelling outside vehicles for the same period.



A discussion paper will be presented to the May Board meeting on the key findings from Phase One and recommendations for Phase Two. The purpose of Phase Two is to explore how we best respond to the issues identified in Phase One.

Proposed programme for further transport safety deep dives

The Safety team are planning to prepare a series of deep dives for the Board to provide further insight and research into key priority areas across AT's span of responsibility. We would welcome feedback on the proposed list of topics which have been prepared to align with early conversations with the Business Improvement Review update and validation:

- Police enforcement with a focus on alcohol and speed enforcement
- Phase Two of the safety of people outside of vehicles
- Safety policy and regulatory settings (e.g. scooter DSI)

Please note that further deep dives for consideration will be proposed in the near future that also cover critical risks across safety outside of transport safety.

3.3 Health and Safety Case Management System

AT's existing Synergi - H&S Incident Management and Reporting tool is currently being upgraded to the latest version which will remove the current impediments around usage and adoption of the tool across AT employees and external partners. The upgrade was expected to be technically ready by end of February as per the initial plan but due to delayed delivery of key bug fixes identified during AT's testing, the software upgrade is now expected to complete User Acceptance Testing (UAT) end of April 2021.

While the original scope of work is to upgrade the solution 'like-to-like' and for browser agility (current Synergi is only compatible with Internet Explorer 11 which is becoming obsolete in August 2021), we have identified the opportunities for further improvements both for reporting and customer experience through a change management strategy. The software upgrade needs to be coupled with a clear map of stakeholders, business processes and user support. It requires a significant change and communication strategy for effective relaunching the tool for both AT internal and external users reminding users to meet their H&S obligation and compliance.

The upgraded software provides a much improved, but different, user experience. For this reason, upgraded Synergi will be 'launched' with our AT and third-party users in conjunction with significant improvements to the key business processes, support and user experience. This level of change requires significant change management and communication activities to ensure that the Synergi 'relaunching' is effective, by preparing the AT internal and external users appropriately and by reminding users of their obligations around Health and Safety and Incident reporting. A specialised Change Manager is being engaged in the project team to lead these aspects and a plan is being worked upon for it to be relaunching by mid May 2021.



3.4 Downtown Infrastructure Development Programme

As highlighted in the February 2021 Safety Board Report, in response to a number of observations and incidents, an independent review of Health and Safety Management^[1] was commissioned with IMPAC, which delivered seven recommendations on 12 August 2020. To ensure continued due diligence, a further independent report^[3] was commissioned early December and delivered 18 December by Van Schaik Safety Solutions (VS) to specifically determine three key areas of enquiry. These related to the identification of critical risks; that the related controls are appropriate to mitigate the critical risk and that the controls have and continue to be effectively implemented.

Our focus now targets a number of layers to increasing the assurance regime through the preparation of a Downtown Infrastructure Development Programme (DIDP) assurance plan. This also includes safety observation visits from the AT Executive; the increased emphasis on verification to further support confidence in the controls regime as well as increasing layers of assurance activities to all three typical 'Lines of Defence' of an assurance model.

The strategic learnings from a risk and assurance perspective are transferable across our delivery portfolio and provides opportunity for AT to lead the lessons across the sector. AT will continue to ensure engagement in this space as part of our overall strategy. From a lesson learned perspective the Safety Team have identified three areas for continual improvement:

1. **Integrated Assurance Framework:** An Integrated Assurance Framework which includes activities at the first, second and third line is currently being developed. Safety Assurance will be part of that integrated approach and be driven by the principals of the integrated assurance framework. The safety team will be supporting the development and lessons learnt from DIDP will be incorporated into the process.
2. **Culture and Leadership:** Safety integration is an initiative currently being developed by the Safety Team and C&T and will ensure that AT achieves our Tiakitanga value. It's how we all work together to weave safety throughout every part of our organisation. It means that across AT we show that safety is key to everyone's role, that we get the safety basics right and together we look for opportunities to implement safety improvements into every decision and action we make.
3. **Resources:** Further resources will be required to provide support in the business units to enable the enhanced level of assurance activities we are required to provide. It is proposed that an iterative approach be used to grow this specific skillset, the first area to be developed is within Integrated Networks.

The DIDP lessons learned pack focusing on areas for improvement is included as an appendix to this report.

^[1] Impac, *Review of Health and Safety Management Downtown Infrastructure Development Programme (DIDP)*, dated 12 August 2020.

^[3] Van Schaik Health and Safety Solutions, *Downtown Joint Venture Critical Risk Review – Executive Report*, dated 18 December 2020.



Next steps are to refresh our enterprise critical and catastrophic risks regime as required by legislation in relation to our activities. This will entail the management of a safety risk revision process including documented identification and engagement of required workers, officers and internal and external stakeholders to ascertain a revised enterprise view of our critical and catastrophic risk in relation to our refreshed horizon scan of our obligations.

Validation of close-out of recommendations from independent reviews

There are a total of 13 recommendations. This relates to the seven recommendations from the IMPAC report and six recommendations from the Van Schaik report. The total of these recommendations and the status of their close-out are now reported through section 6 of this report and will continue to be until verified as delivered and closed. The DIDP Assurance Plan incorporates the final activities required to close these recommendations and seek their independent validation in April.

4. Organisation

This section aims to ensure the state of safety of the organisation at the end of the reporting period. This includes notifications to regulators, as this provides for a system-wide view of where defences are being breached.

4.1 Status Summary for inputs to the Safety Framework

Table 1 – Status summaries

Level	Intent	Status
Strategy	Safety Strategy Development	Safety vision, values and policy to enable the Safety Strategy 2021-24 scoping commenced with a board workshop date to be proposed at the earliest possible time. This Strategy development will involve organisation wide agreement on targets and will be co-designed with the business.
	Vision Zero	The Road Safety Programme Business Case reforecast is being confirmed by Service Delivery and Safety, and finalised information is expected to be presented to ELT and the AT Board in May.
System	AT Safety Management System Development	Review of current procedures and policies is underway to identify key improvement opportunities prior to completion of Safety Strategy in Q2 2021/22*. This will build on DIDP recommendations and areas of improvement. An AS/ANS ISO 45001 Health and Safety Accreditation Stage 1 audit will take place in Q2 to coincide with the safety strategy completion.



Level	Intent	Status
Review	Road Safety Business Improvement Review 2018	Eric Howard of Whiting Moyne is undertaking a review of the progress made on the recommendations in the Road Safety Business Improvement review (BIR) and also call out focus areas on what can be done to collectively lift the road safety performance in Tāmaki Makaurau. Interviews have been conducted with key partners, including leaders from Waka Kotahi, NZ Police and Ministry of Transport (MoT) to provide their perspective into the report. The final draft report will be submitted by Whiting Moyne in April to AT Safety Team and will be shared with the AT Board after.
Review	AT Critical Risk Review	Review of the current critical and catastrophic risks and their controls and ownership has commenced including appropriate methodology for a safety risk assessment within the enterprise Organisational Risk Management Framework.

*Quarters align with financial years.

4.2 Notifications to NZ Regulators

There were four events that were notified to regulators during this reporting period, two in both January and February.

Table 2 – January and February Notifications to NZ Regulators

Date	Description of Event	Notification to Regulator
8 January	<p>A partial trench collapse occurred on the Karangahape Road Streetscape project while preparing to pour the concrete for the reinforced walls of one of the rain gardens. The trench depth was measured at 1.7 meters and there were no mitigating controls in place to prevent a collapse. The material that sloughed off was contained by the rebar that was already in place. The trench was unoccupied at the time of the event.</p> <p>Status: A WorkSafe inspector visited the site and issued a prohibition notice to prevent further work taking place. The contractor subsequently made the work area safe, and the prohibition notice was lifted. A site visit involving the contractor, AT project manager and safety team took place, and it was agreed that the contractor would update their standard operating procedures to prevent a recurrence.</p>	Notified to WorkSafe (Synergi 24480)



Date	Description of Event	Notification to Regulator
31 January	<p>KiwiRail contractors were working on what was thought to be a portion of protected track at the Wiri depot. A CAF shunter was given authorisation to shunt an AT electric multiple unit onto the same portion of track. This caused the KiwiRail protection officer to raise an incident with the network control manager who then stood up the rail incident commander.</p> <p>Status: The initial cause of the event has been identified as a miscommunication between the KiwiRail protection officer and one of the signallers at Wiri. The incident is still under investigation.</p>	Notified to NZTA (Synergi 24665)
5 February	<p>A bus driver was crushed between two buses while walking towards his vehicle at the start of his shift. Another employee was moving a bus which the driver was not aware of.</p> <p>Status: WorkSafe has notified the operator that they will be investigating the incident.</p>	Notified to WorkSafe (Synergi 24716)
11 February	<p>Following a substantial amount of rain, a traffic light pole, which included an over road mast and integrated streetlight, fell into the live traffic lane. Excavation around the pole was in progress as part of kerb and channel works being undertaken on the Glen Eden town centre safety improvements project. The traffic management plan was under stop/go control at the time of the incident. There were no injuries and no damage to property.</p> <p>Status: Investigation into the event has been finalised. The pole was old, and the foundation was found to be too shallow when compared to current installation standards. In future, the contractor will ensure that temporary traffic lights are setup and all accessories such as the lantern removed from the pole to reduce the risk of collapse, prior to starting excavation. This will reduce the weight and the effects of wind on the structure.</p>	Notified to WorkSafe (Synergi 24810)


Lessons learned around what AT have done in response to these events and establishing a close out process requires greater focus for the Safety Team moving forward. It is proposed that the events previously notified to the Board will then be a standing item at the proposed Safety and Regulatory Committee to close the loop and give Directors visibility on trends, risks and controls.




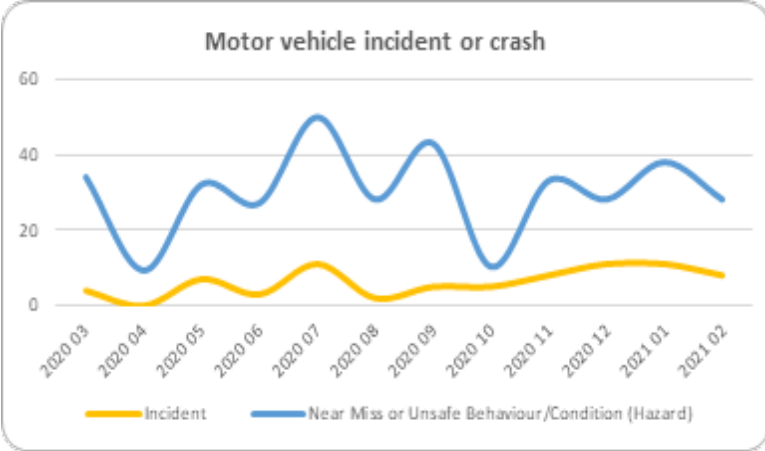

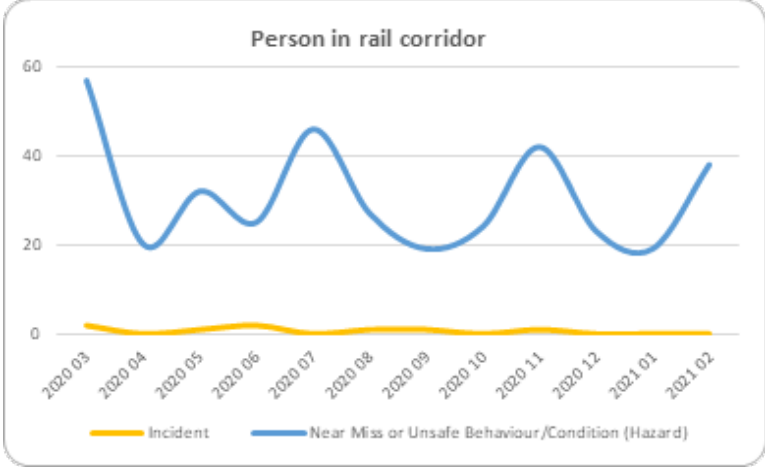
4.3 Safety Critical Risk Areas Update

A Critical Risk (CR) is a risk that has an assessed risk score of 15 and above on the AT Risk Matrix. AT's CRs are the risks that are most likely to cause single or multiple significant or disabling injuries, and/or a fatality. The table on the following pages highlights the AT CR areas that have had notable events during January and February 2021.


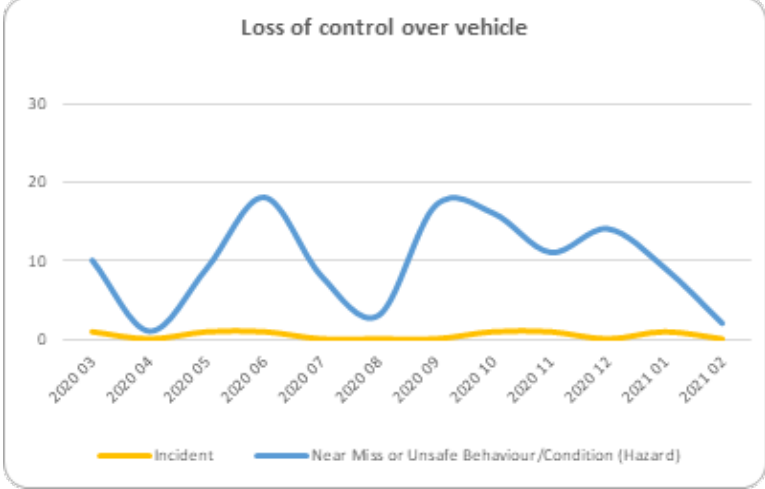

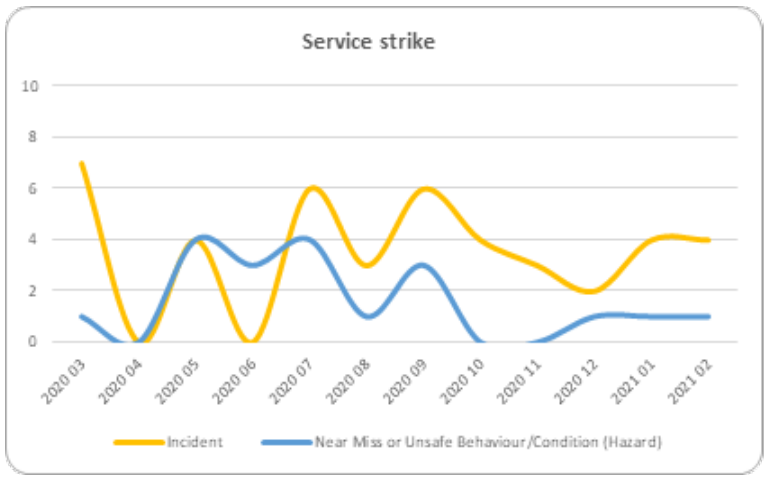
Table 3 – Top Five Critical Risks

Critical Risk		Comments	Trends																																							
Threats and Aggression		<p>An improving trend during the reported period as the de-escalation training for AT workers is continued to be implemented.</p> <p>The previous incidents involving cashbox thefts have tapered off due to them no longer being on buses, but any reintroduction of cashboxes needs to consider the enhanced risk profile.</p>	<div data-bbox="1352 603 2114 1082"> <p style="text-align: center;">Threats and aggression towards AT staff</p> <table border="1"> <caption>Approximate data from Trends chart</caption> <thead> <tr> <th>Month</th> <th>Incident (Yellow)</th> <th>Near Miss or Unsafe Behaviour/Condition (Hazard) (Blue)</th> </tr> </thead> <tbody> <tr><td>2020 03</td><td>28</td><td>28</td></tr> <tr><td>2020 04</td><td>0</td><td>15</td></tr> <tr><td>2020 05</td><td>5</td><td>20</td></tr> <tr><td>2020 06</td><td>18</td><td>25</td></tr> <tr><td>2020 07</td><td>10</td><td>20</td></tr> <tr><td>2020 08</td><td>15</td><td>25</td></tr> <tr><td>2020 09</td><td>25</td><td>18</td></tr> <tr><td>2020 10</td><td>15</td><td>20</td></tr> <tr><td>2020 11</td><td>15</td><td>42</td></tr> <tr><td>2020 12</td><td>5</td><td>25</td></tr> <tr><td>2021 01</td><td>2</td><td>35</td></tr> <tr><td>2021 02</td><td>2</td><td>22</td></tr> </tbody> </table> </div>	Month	Incident (Yellow)	Near Miss or Unsafe Behaviour/Condition (Hazard) (Blue)	2020 03	28	28	2020 04	0	15	2020 05	5	20	2020 06	18	25	2020 07	10	20	2020 08	15	25	2020 09	25	18	2020 10	15	20	2020 11	15	42	2020 12	5	25	2021 01	2	35	2021 02	2	22
Month	Incident (Yellow)	Near Miss or Unsafe Behaviour/Condition (Hazard) (Blue)																																								
2020 03	28	28																																								
2020 04	0	15																																								
2020 05	5	20																																								
2020 06	18	25																																								
2020 07	10	20																																								
2020 08	15	25																																								
2020 09	25	18																																								
2020 10	15	20																																								
2020 11	15	42																																								
2020 12	5	25																																								
2021 01	2	35																																								
2021 02	2	22																																								



Critical Risk		Comments	Trends																																							
Motor vehicle incident or crash (Motor vehicle operation)		<p>One of the 19 incidents for January and February was a WorkSafe notifiable event involving a bus driver.</p> <p>A bus driver was walking along the demarcated path in the Go Bus depot in Mangere to start his shift. At the same time, a bus was being moved out of a parking bay, and the tail swing caused the rear of the bus to intrude into the demarcated path, crushing the bus driver between the two buses. An investigation is currently being undertaken by WorkSafe. We believe it is in our remit and we do have accountability as a PCBU as both drivers were in AT uniforms and about to start on an AT service. WorkSafe is currently undertaking their investigation and we have requested their report once completed from Go Bus.</p>	<p style="text-align: center;">Motor vehicle incident or crash</p>  <table border="1"> <caption>Motor vehicle incident or crash trends</caption> <thead> <tr> <th>Month</th> <th>Incident</th> <th>Near Miss or Unsafe Behaviour/Condition (Hazard)</th> </tr> </thead> <tbody> <tr><td>2020-03</td><td>5</td><td>35</td></tr> <tr><td>2020-04</td><td>2</td><td>10</td></tr> <tr><td>2020-05</td><td>8</td><td>32</td></tr> <tr><td>2020-06</td><td>5</td><td>28</td></tr> <tr><td>2020-07</td><td>12</td><td>50</td></tr> <tr><td>2020-08</td><td>5</td><td>30</td></tr> <tr><td>2020-09</td><td>8</td><td>45</td></tr> <tr><td>2020-10</td><td>5</td><td>10</td></tr> <tr><td>2020-11</td><td>10</td><td>35</td></tr> <tr><td>2020-12</td><td>12</td><td>30</td></tr> <tr><td>2021-01</td><td>10</td><td>40</td></tr> <tr><td>2021-02</td><td>8</td><td>30</td></tr> </tbody> </table>	Month	Incident	Near Miss or Unsafe Behaviour/Condition (Hazard)	2020-03	5	35	2020-04	2	10	2020-05	8	32	2020-06	5	28	2020-07	12	50	2020-08	5	30	2020-09	8	45	2020-10	5	10	2020-11	10	35	2020-12	12	30	2021-01	10	40	2021-02	8	30
Month	Incident	Near Miss or Unsafe Behaviour/Condition (Hazard)																																								
2020-03	5	35																																								
2020-04	2	10																																								
2020-05	8	32																																								
2020-06	5	28																																								
2020-07	12	50																																								
2020-08	5	30																																								
2020-09	8	45																																								
2020-10	5	10																																								
2020-11	10	35																																								
2020-12	12	30																																								
2021-01	10	40																																								
2021-02	8	30																																								
Person in rail corridor (Train operation)		<p>The majority of cases (95%) reported over this reporting period are unsafe behaviours (lead indicators), relating to trespassing and tagging.</p> <p>There was one notifiable incident reported in January to Waka Kotahi involving a Kiwirail worker. No injuries were sustained by any workers on site.</p>	<p style="text-align: center;">Person in rail corridor</p>  <table border="1"> <caption>Person in rail corridor trends</caption> <thead> <tr> <th>Month</th> <th>Incident</th> <th>Near Miss or Unsafe Behaviour/Condition (Hazard)</th> </tr> </thead> <tbody> <tr><td>2020-03</td><td>2</td><td>55</td></tr> <tr><td>2020-04</td><td>1</td><td>20</td></tr> <tr><td>2020-05</td><td>2</td><td>32</td></tr> <tr><td>2020-06</td><td>2</td><td>25</td></tr> <tr><td>2020-07</td><td>1</td><td>45</td></tr> <tr><td>2020-08</td><td>1</td><td>30</td></tr> <tr><td>2020-09</td><td>1</td><td>20</td></tr> <tr><td>2020-10</td><td>1</td><td>25</td></tr> <tr><td>2020-11</td><td>1</td><td>42</td></tr> <tr><td>2020-12</td><td>1</td><td>20</td></tr> <tr><td>2021-01</td><td>1</td><td>18</td></tr> <tr><td>2021-02</td><td>1</td><td>38</td></tr> </tbody> </table>	Month	Incident	Near Miss or Unsafe Behaviour/Condition (Hazard)	2020-03	2	55	2020-04	1	20	2020-05	2	32	2020-06	2	25	2020-07	1	45	2020-08	1	30	2020-09	1	20	2020-10	1	25	2020-11	1	42	2020-12	1	20	2021-01	1	18	2021-02	1	38
Month	Incident	Near Miss or Unsafe Behaviour/Condition (Hazard)																																								
2020-03	2	55																																								
2020-04	1	20																																								
2020-05	2	32																																								
2020-06	2	25																																								
2020-07	1	45																																								
2020-08	1	30																																								
2020-09	1	20																																								
2020-10	1	25																																								
2020-11	1	42																																								
2020-12	1	20																																								
2021-01	1	18																																								
2021-02	1	38																																								



Critical Risk		Comments	Trends																																							
<p>Loss of control over vehicle (TTM)</p>		<p>The majority of the reported events where unsafe behaviour/condition such as inadequate temporary traffic management on site and reported in the portfolio delivery space (Asset & Maintenance).</p>	<p>Loss of control over vehicle</p>  <table border="1"> <caption>Loss of control over vehicle - Trend Data</caption> <thead> <tr> <th>Month</th> <th>Incident</th> <th>Near Miss or Unsafe Behaviour/Condition (Hazard)</th> </tr> </thead> <tbody> <tr><td>2020-03</td><td>1</td><td>10</td></tr> <tr><td>2020-04</td><td>1</td><td>2</td></tr> <tr><td>2020-05</td><td>1</td><td>10</td></tr> <tr><td>2020-06</td><td>1</td><td>18</td></tr> <tr><td>2020-07</td><td>1</td><td>10</td></tr> <tr><td>2020-08</td><td>1</td><td>5</td></tr> <tr><td>2020-09</td><td>1</td><td>18</td></tr> <tr><td>2020-10</td><td>1</td><td>15</td></tr> <tr><td>2020-11</td><td>1</td><td>12</td></tr> <tr><td>2020-12</td><td>1</td><td>15</td></tr> <tr><td>2021-01</td><td>1</td><td>10</td></tr> <tr><td>2021-02</td><td>1</td><td>5</td></tr> </tbody> </table>	Month	Incident	Near Miss or Unsafe Behaviour/Condition (Hazard)	2020-03	1	10	2020-04	1	2	2020-05	1	10	2020-06	1	18	2020-07	1	10	2020-08	1	5	2020-09	1	18	2020-10	1	15	2020-11	1	12	2020-12	1	15	2021-01	1	10	2021-02	1	5
Month	Incident	Near Miss or Unsafe Behaviour/Condition (Hazard)																																								
2020-03	1	10																																								
2020-04	1	2																																								
2020-05	1	10																																								
2020-06	1	18																																								
2020-07	1	10																																								
2020-08	1	5																																								
2020-09	1	18																																								
2020-10	1	15																																								
2020-11	1	12																																								
2020-12	1	15																																								
2021-01	1	10																																								
2021-02	1	5																																								
<p>Service Strike (work area with passing services)</p>		<p>There were eight incidents and two unsafe behaviour/conditions over the reporting period, relating to a gas strike from excavation work resulting in property damage.</p> <p>We generally expect to see the reported number of near misses and unsafe behaviour to be higher than the number of incidents, which is the case across other critical risks. Service strikes is trending differently.</p> <p>Although some incidents are isolated, an identified issue commonly associated with these service strikes is related to AT's relationship with the utility service providers. This is an area of focus for the Safety Team.</p>	<p>Service strike</p>  <table border="1"> <caption>Service strike - Trend Data</caption> <thead> <tr> <th>Month</th> <th>Incident</th> <th>Near Miss or Unsafe Behaviour/Condition (Hazard)</th> </tr> </thead> <tbody> <tr><td>2020-03</td><td>7</td><td>1</td></tr> <tr><td>2020-04</td><td>0</td><td>0</td></tr> <tr><td>2020-05</td><td>4</td><td>4</td></tr> <tr><td>2020-06</td><td>0</td><td>3</td></tr> <tr><td>2020-07</td><td>6</td><td>4</td></tr> <tr><td>2020-08</td><td>3</td><td>1</td></tr> <tr><td>2020-09</td><td>6</td><td>3</td></tr> <tr><td>2020-10</td><td>4</td><td>0</td></tr> <tr><td>2020-11</td><td>2</td><td>0</td></tr> <tr><td>2020-12</td><td>2</td><td>1</td></tr> <tr><td>2021-01</td><td>4</td><td>1</td></tr> <tr><td>2021-02</td><td>4</td><td>1</td></tr> </tbody> </table>	Month	Incident	Near Miss or Unsafe Behaviour/Condition (Hazard)	2020-03	7	1	2020-04	0	0	2020-05	4	4	2020-06	0	3	2020-07	6	4	2020-08	3	1	2020-09	6	3	2020-10	4	0	2020-11	2	0	2020-12	2	1	2021-01	4	1	2021-02	4	1
Month	Incident	Near Miss or Unsafe Behaviour/Condition (Hazard)																																								
2020-03	7	1																																								
2020-04	0	0																																								
2020-05	4	4																																								
2020-06	0	3																																								
2020-07	6	4																																								
2020-08	3	1																																								
2020-09	6	3																																								
2020-10	4	0																																								
2020-11	2	0																																								
2020-12	2	1																																								
2021-01	4	1																																								
2021-02	4	1																																								



5. Performance

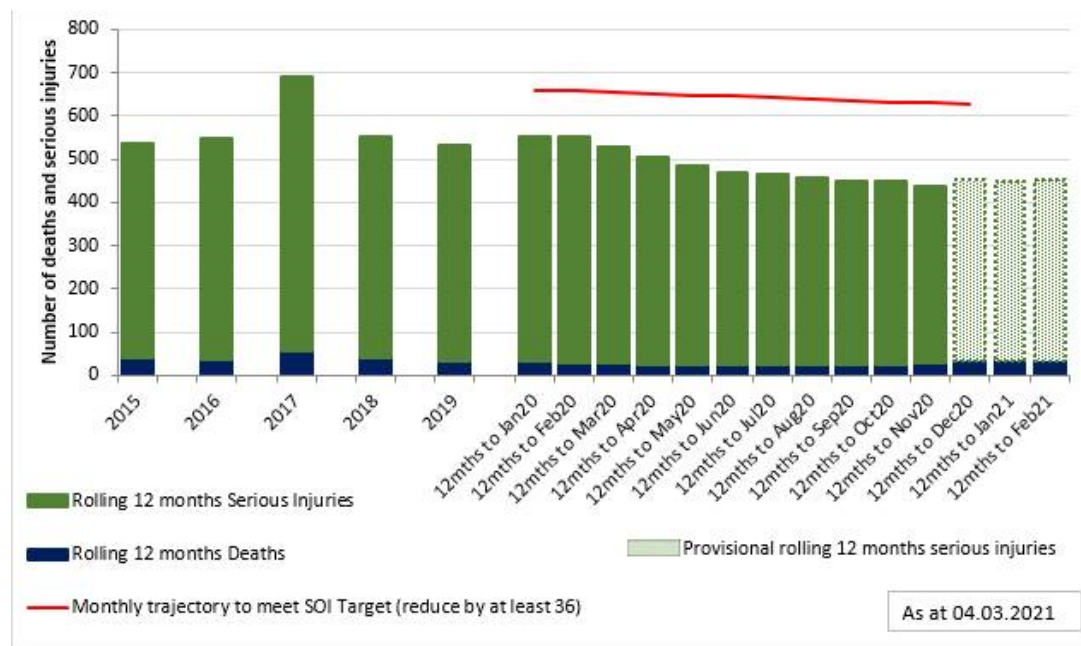
5.1 Safety Performance Dashboard

A safety performance dashboard has been included on the following page.

Once the Safety Strategy has been developed, further measurements of safety performance can be added to this dashboard.

5.2 Statement of Intent

The 12month rolling total for DSI to November 2020 is 437, 31% lower than the SOI November target of 630 for 2020. The Local Road DSI target for the 2020 calendar year is 627. The 12-month rolling total for DSI to November 2020 is also lower than the five-year average by 135 DSI or 24%. The 12-month rolling total of DSI to November 2020 is lower than the rolling 541 DSI total for the year 2019 by 19%.



**Local Roads are roads that are operated by Auckland Transport. Please note that there is a three-month time lag for local road death and serious injuries information, and that monthly figures can vary over time due to Police investigation outcomes and reporting timelines. **Please note that historically there has been and still is a lag of up to three months for road serious injury information from Waka Kotahi and as such the serious injury data is only shown up to end of September. However, we are presently working with Waka Kotahi on how we might address this*

Figure 3 - Local Road DSI SOI Update to November 2020 (provisional to December 2020)

Safety Performance Dashboard for January and February 2021

9 FATALITIES in January and February 2021 on Tāmaki Makaurau Roads

THREE drivers

ONE person on foot

THREE motorcyclists

TWO passengers

7 AT EMPLOYEE INJURIES

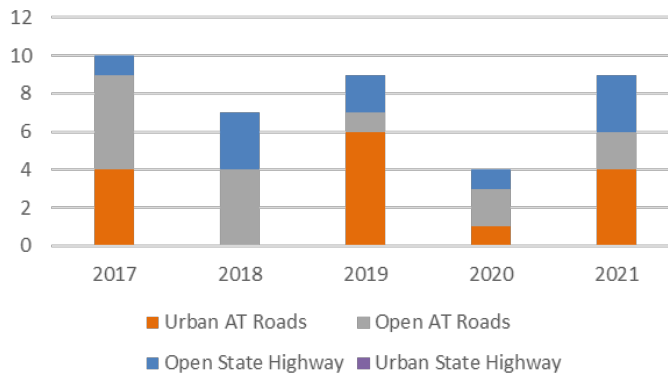
THREE parking compliance officers

THREE transport compliance officers

ONE customer care representative

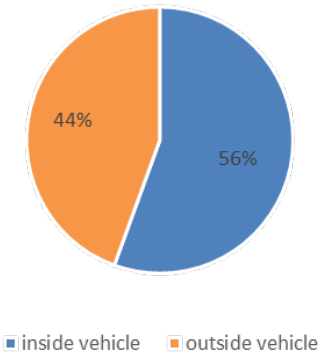
In 2021, 67% of road deaths have occurred on AT roads. Of the AT road deaths, 67% were on urban AT roads and 33% on open AT roads.

All Auckland road deaths by road type (Jan – Feb 2017 to 2021)



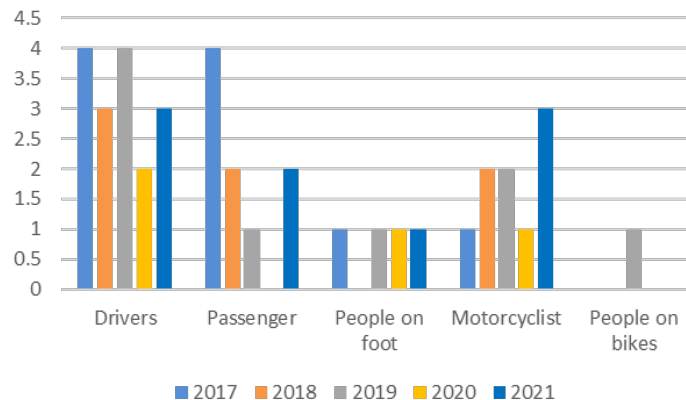
44% of road deaths in 2021 have so far been outside of the vehicle. Motorcyclists make up 33% of all road deaths in Auckland.

Proportion of inside/ outside vehicle deaths (year to date)



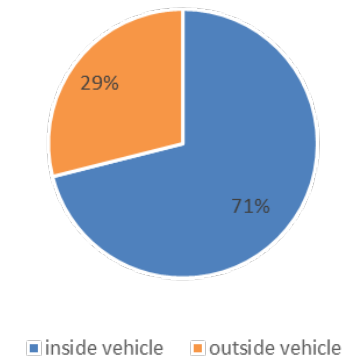
In 2021, compared to the five-year average, our vulnerable road-user deaths are trending upwards, particularly motorcyclists.

All Auckland road deaths by mode of travel (Jan - February 2017 – 21)



Deaths of vulnerable road users continues to be an upward trend.

Proportion of inside/ outside vehicle deaths (five year average)





6. Monitoring and Assurance

6.1 Board Health and Safety Engagement Activities

The following visits were undertaken by board members during the reporting period:

Table 4 - Site visits undertaken by board members in January and February

Name	Site visited	Date
Wayne Donnelly	Wolverton Street Culverts. This visit was cancelled due to COVID-19 level two and three restrictions at the time.	Cancelled
Dr Jim Mather	Puhinui Road (Short Term Airport Access Improvements). Dr Mather noted that an impressive culture of safety exists on the site and that all workers emphasise this. He was not wearing long-sleeves and was rightly denied access to the site. Being a roading project, the visit could be conducted from the footpath. He further noted that it was a very orderly and tidy site, especially given the dynamic nature.	24 February

6.2 Audit and Assurance Activity

Status of external reviews in relation to critical risk management

The following summaries reflect the status of recommendations from external reviews into safety and risk management for the reporting period and will continue to remain within this report until verified as closed, which will be reported to the board.

Status of Close-Out of Fatal Crash Investigations

As a road controlling authority, AT are responsible for completing fatal crash investigations for all road deaths that occur on the local road network. These investigations are led by Road Safety Engineering and the final report is submitted to the Coroner. A separate report is also completed by the Police serious crash unit and submitted to the Coroner. An investigation into the overall process including the recommendation close-out process will be undertaken as a priority by the Safety Team. A summary of recommendations and close-outs overall will be provided as soon as possible.



Table 5 - Status of External Reviews

Date released	Title	Number of Recommendations	Number of Recommendations Open	Verification of Closed Recommendations (indicate if independent verification)
12 August 2020	IMPAC Review of Health and Safety Management – DIDP	7	7 Provisionally completed in Feb 2021, subject to independent validation	Independent validation underway, completion due in mid-April 2021
18 December 2020	Van Schaik Health and Safety Solutions, Downtown Joint Venture Critical Risk Review – Executive Report	6	6	Independent validation will be carried out in April 2021
15 January 2021	Van Schaik Report, Downtown Joint Venture Critical Control Evidence Review Summary Report	5	5	Independent validation will be carried out in April 2021

6.3 Critical Control Verification

The following number of controls have been assessed in detail against Verification Expectations as set out in the report referred to below. This control verification activity relates to the ongoing management of the DIDP critical risk improvements. They will remain in this board report until verified as closed or that the re-submitted documentation meets requirements to enable verification.

Table 6 – Controls Verification Activity

Evidence Summary	Controls Verified against Verification Expectation	Summary of Recommendation
Van Schaik Report, Downtown Joint Venture Critical Control Evidence Review Summary Report, dated 15 January 2021.	8	The Downtown JV has developed a 'Site Audit and Critical Risk Controls' form to support weekly verification reporting. The Downtown JV has revised their HSEMP.



Appendix – DIDP Lessons Learned

Downtown Programme - Critical Safety Risks

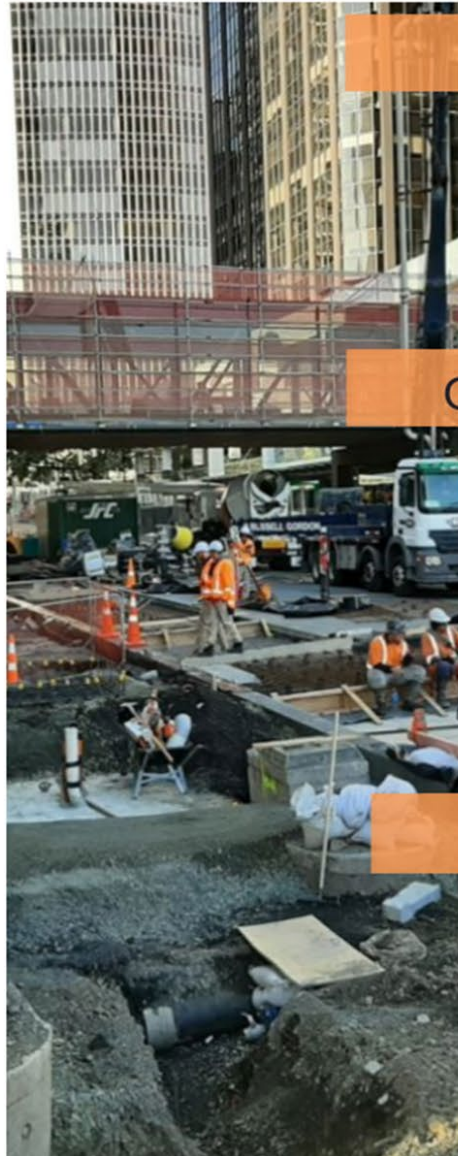


Key Client Learnings



Key Learnings

Challenges



Interpretation of Risk

The governance and programme design would have benefited from the setting of clearer framework level expectations and also the joint risk assessing throughout the life of the programme.

Governance Arrangement in a JV

Terms of Reference for the PCG and PMB appear confused at times between the governance of a programme as a system, structure and that of individual projects. This may have contributed to the individual project focus rather than the inherent requirements of the DJV as a PCBU at the programme level

Programme Design

The programme would have benefited from incorporating more robust structure to strengthen overlapping duties further,



Assurance Framework: Van Schaik Solutions, AT Critical Risk Review December 2020





Key Learnings

Downtown Critical Risks - Client Areas for Improvement



System Set Up and Safety Strategy from the start is important - heightened in a Joint Venture scenario with multiple parties and overlapping duties. Important to have an overarching HSEMP and clear lines of accountability



AT role clarity on 1st line, 2nd line 3rd line, a one team approach and transparent communication can bring improved focus and understanding of trending issues and responses



Strong visible safety leadership from the 1st Line and broader AT business is important to 'walk to talk' - hand in hand with this giving our teams the tools to have real safety conversations and how we can support PCBU's



Strategic Leadership footprint including involvement from Senior Leaders (client, designer and contractor) can support driving a positive safety culture through the whole programme



Working collaboratively and harnessing industry best practice from our suppliers can move the whole of industry dial - we have an important leadership role to play



Key Learnings

Downtown Critical Risks - Client Areas for Improvement



Establish stronger anchoring of the Client's role at the upstream part of the lifecycle, including at the point of concept and design pre-programmes/projects



Increase the evaluation and assurance activities throughout the lifecycle of capability management (concept and design onwards) in P3M activities to embed requirements at key stages.



Setting of the Assurance Framework Upstream



Increase the portfolio level view of safety performance at the Client level to ensure oversight of the lifecycle from a safety perspective



Clarity on named responsibilities in management groups, governing groups (PCG) and boards (PMB, JV board) in the deliberation, acceptance, transfer or escalation of safety risk.