Attachment 1 – March 2023 Safety Business Report Dashboard

1. Health, safety and wellbeing dashboard

- 1.1. Safety, health and wellbeing strategy
- 1.2. Safety management system
- 1.3. Safety assurance and legal environment
- 1.4. Safety operational activity
- 1.5. Supplier management

2. Road safety dashboard

- 2.1. Road safety performance
- 2.2. Fatal crash reporting

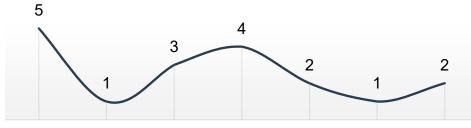


1. Health, safety and wellbeing dashboard



1.1 Safety, Health and Wellbeing (SHW) strategy - Auckland Transport

Leadership Leaders leading safety Leadership safety walks progress Focus on completing walks for senior leaders

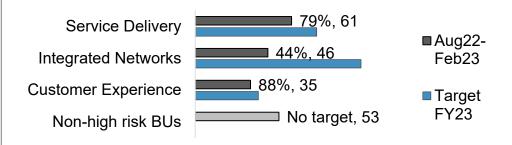


Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23

Context: Currently the leadership safety walks are only conducted by board members who aim to complete one safety walk every quarter.

Update: One safety leadership walk consisted of a flood recovery visit to Bethell's Beach. Topics included violence, threats and aggression against traffic management members. Overall, the site was well organised and the site team take safety seriously. Second safety leadership walk conducted at a Britomart train station (secant piles).

Safety leadership training progress Focus on completing in high risk operational areas



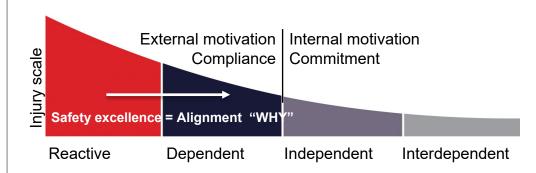
Context: Safety leadership training is part of the "Leading at AT Programme". Our goal is to train all leaders in Customer Experience (CX), Integrated Networks (IN) and Service Delivery (SD) before the financial year end 2023.

Update: Progress in SD and CX is largely attributed to "targeted" training workshops to groups outside the Leading at AT programme. A similar "targeted" approach can be taken with outstanding groups. Flood response and prioritising person conducting a business or undertaking (PCBU) workshops has attributed to the lack of uptake currently.

Engagement Positive change in safety culture

Culture engagement progress

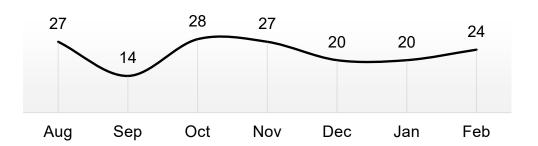
Focus on greater safety culture maturity



Context: Target a shift in safety culture category for AT overall from reactive to dependent, measured via the Bradley curve.

Update: Measured for the first time in September 2021 and indicated that AT had an early "reactive" safety culture. AT will remeasure by way of an internal survey in May 2023, with results available in June. Early indications from the interim pulse surveys are positive.

Critical safety risks implementation progress Focus on identifying and implementing action plans



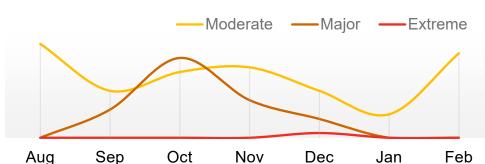
Context: Development of a framework to manage critical Health & Safety risks across AT

Update: Critical risks have been identified and owners allocated to each risk. This forms the basis of the action plan.

Safe systems Data driven insights influencing design

Learning reviews progress

Focus on completing for all moderate to extreme events

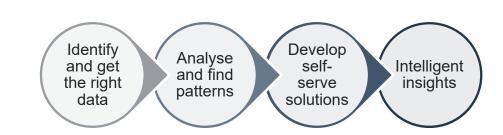


Context: A full learning review or a simple learning review will be conducted in response to an adverse event in Synergi based on the classification and risk consequence. Adverse events with a risk consequence of extreme or major will require the Safety Enablement team to conduct a full learning review. Simple learning reviews are conducted by AT people leaders for moderate and minor adverse events.

Update: Synergi is currently being redesigned to incorporate improved process and tracking of learning reviews.

Data eco-system progress

Focus on improving harm reporting and insights



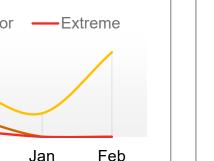
Context: Underreporting in transport harm has been reported and our goal is to better use data to improve decision making and understanding across the transport network.

Update: Requirements scoping completed and approval process started to share Ministry of Health (MOH), Accident Compensation Corporation (ACC) and Crash Analysis System (CAS) data to analyse transport harm. Dashboard was initiated as part of a gap analysis of the road safety programme business case. The executive dashboard for health, safety and wellbeing experienced a technical delay and revised delivery to the Safety team is early March 2023.

Advocacy Progress against advocacy plan

Advocacy plan progress

Focus on influencing government to improve transport policies



Enforcement General deterrence

Technology Safety cameras

Context: 2021 Road Safety Business Improvement Review (BIR) identified policy responses at central government level to achieve Vision Zero. In 2022, AT advocacy priorities focused on fines and penalties framework review, roll out of safety cameras and improving police enforcement.

Update: Safety cameras construction has started on nine of 10 sites. AT continues to partner with NZ Police for greater enforcement and to wait for Cabinet decision to consult on penalties framework with no further action required.

Penalties

Framework review

Safety governance forum progress

Focus on engagement and inclusion of the transport network



Context: Establish an affective transport safety engagement group that includes key contracted operators and suppliers by the end of the financial year 2023.

Update: An external transport inclusive safety forum is well established. Customer behaviour toward staff in Metro and temporary traffic management (TTM) during the Covid19 and the recent flooding has contributed to an increase in violence, threats and aggression. Key partners have been identified to join the group in March / April and a first priority is to tackle safety of bus drivers and TTM personnel.



AT SMS framework progress

Context

The SMS framework is the foundation of AT's health and safety system. It aligns with ISO 45001 and is an essential supporting organisational structure to ensure professional management and innovation with safety across Auckland Transport.

There is significant work to be completed to ensure the SMS meets the required standard. Please note that the SMS activities listed on this slide are only part of the overall framework (under development).

Key progress and insights

- The current SMS workstreams and elements from the Van Schaik 2022 Business Improvement Review will be integrated into the ISO 45001 framework. An action plan has been submitted for endorsement at the March 2023 safety committee meeting.
- An SMS framework has been submitted for endorsement at the March 2023 safety committee meeting. It is currently proposed that ISO 45001 Occupational Health and Safety Management System is adopted for AT's SMS Framework, including six critical elements:

Key risks

 The key risk for the AT SMS Framework is resource availability for development and implementation activities within the Safety team and across the organisation. This is mitigated by effective prioritisation of the SMS activities, with the most critical aspects currently underway.



Key initiatives

Initiatives	Goal	Stage	Progress and insights	Risks
Critical risk	Development of framework to manage critical health and safety risks across AT and networks.	Implementation	Current focus is on completing the critical risk implementation and verification plan. Responsibility for activities has been assigned across the Safety team.	Recent staffing changes requiring a reprioritisation of activities.
Health and safety risk framework programme	Development of a framework for health and safety risk management across AT.	Development	Review of current activities within the business and the current health and safety risk management procedure.	Agreement on selection of appropriate technology solution for managing operational health and safety risk.
Safety in procurement	Development of a health and safety risk management standard for contract management.	Development	Current activity is development of a draft document for agreement between the safety and procurement teams.	Complex document requires a number of stakeholders to jointly agree on the standards, requirements and resulting activities.
Person conducting a business or undertaking (PCBU)	Development of contractor health and safety management framework.	limplementation	The PCBU framework is currently being implemented in Integrated Networks, with a focus on relationship mapping and providing support to other PCBUs as required. Planning is underway to advance full PCBU implementation in Service Delivery, and initial workshops and conversations have occurred in Customer Experience.	Resource availability across the organisation to implement the PCBU framework. Capability and knowledge of other PCBUs to meet consultation, cooperation and co-ordination requirements.
MPOWER (worker engagement and representation in occupational health & safety)	Development of worker engagement, participation and representation framework.	Launch	The MPOWER framework is ready for launch on 21 March 2023. Implementation planning for year one of the programme is underway and will commence post-launch.	Resource and availability to implement the year one MPOWER programme, including availability of safety, health and wellbeing representatives to commit up to two hours per week to the required activities.
Safety capability	Development of safety resources to increase knowledge and capability across AT.	Development	Module two is focused on refreshing the safety, health and wellbeing induction. A wireframe layout has been agreed with the external designer.	Significant amount of work to be completed by 19 May 2023 deadline.



1.3 Safety assurance and legal environment - Auckland Transport

Safety assurance review progress

Context

Safety assurance activities are conducted by safety subject matter experts. Safety assurance audits are currently carried out against the international best practice standard ISO 45001 Occupational Health and Safety, while our safety management system (SMS) continues to be developed and grows in maturity. The safety assurance process is currently an indication of the base line for future reference. with flexibility to shift focus to key areas throughout the year.

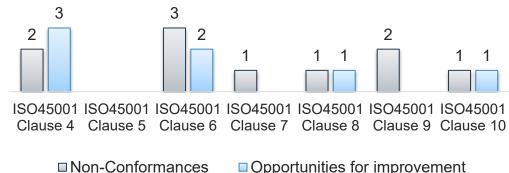
Key progress and insights

- In alignment of ISO 45001 Occupational Health and Safety trends analysis two desktop reviews took place, PMO and Safety Hub documentation. The top three finding areas were in safety management systems, hazard identification and assessment of risks and opportunities, and continual improvement. Appropriate actions have been agreed upon and are moving forward.
- Safety assurance walks consists of flood recovery activities

Key risks

• The majority of our findings are organisational factors due to the SMS development stage. However, we are able to add value to the BU's by offering and building solutions and support that are in alignment with ISO 45001 best practice.

Audit result findings for February 2023



Opportunities for improvement

Legend

Clause 4 – context of organisation

Clause 5 – leadership and worker participation

Clause 6 – planning

Clause 7 – Support

Clause 8 - Operations

Clause 9 – Performance evaluation

Clause 10 - Improvement

SPOTLIGHT - Flood recovery

The key theme identified during flood recovery safety assurance activities was frontline management systems for a person conducting a business or undertaking (PCBU). Discussions with the contractor and have assisted with actions to address the findings. Actions include AT attending the contractor's safety meeting to reinforce client expectations and review of de-escalation training providers. The contractor has taken our concerns seriously and is in the process of rapid improvements. We will continue to monitor and find ways to support the contractor. Other contractors have maintained a reasonable level of safety on site.

There were a total of four flood recovery incidents which included elements of violence, threats and aggression from the public.

Safety is heading a reflection review and capturing what went well and identifying opportunities for improvement.

January/February 2023 update

eb 23	_	
00 <u>2</u> 0	Progressed	Actions agreed and underway.
eb 23	Progressed	Report being peer reviewed.
eb 23	Progressed	ATW Procedure, permit to work procedure, leadership safety conversations procedure, leadership safety walk supporting guidelines and collateral built.
/lar 23	Upcoming	EGM leadership safety walk have been scheduled for 15 March 2023.
	Completed	The leadership safety walks assurance tool has been developed in Synergi.
	Progressed	Synergi tools for assurance activities are being developed including safety conversations, ISO 45001 report form, safety assurance specialists, facility inspection forms and project management assurance.
//	eb 23 ar 23	eb 23 Progressed ar 23 Upcoming

Safety legal environment

Context

Update on recent legal cases and other regulatory activity that may impact AT, including recommended actions where applicable.

January/February 2023 update

No critical changes or new legislation impacting AT.

Case law and legislation

- Fulton Hogan Ltd pleaded guilty to a s34 charge under the Health and Safety at Work (HSW) Act 2015 and was fined after an employee was struck and killed by a driverless runaway truck in Wellington in March 2019. The driver of the truck, an employee of a subcontractor, was injured in attempting to climb back on board his vehicle. Fulton Hogan had extensive health and safety (H&S) documentation, including pictorial guidance for truck parking on slopes; however, not all these documents were made available to subcontractors, the company instead relying on tailgate meetings to pass on relevant H&S information. Fulton Hogan's processes and monitoring failed to identify all other PCBUs working at the site, and therefore failed to ensure all workers on site had been informed of safe systems of work and its H&S expectations. "Fulton Hogan provided greater health and safety direction to its direct employees," noted the court, "than to workers of contractors and subcontractors, despite them being exposed to the same risks."
 - The external investigator's report into this fatality recommended prosecution of Waka Kotahi and Vehicle Testing New Zealand. WorkSafe did not pursue this as in their view the requirements of the Solicitor-General's prosecution guidelines were not met.
 - This case is currently being reviewed by the AT Safety Team and advice is being sought from AT Legal Counsel regarding any implications for the way we manage PCBUs and subcontractors.

Regulatory activity

 A Transport Accident Investigation Commission (TAIC) investigation into a fatal collision between a train and a truck parked over the track found a contractor's failure to inform KiwiRail that its work could encroach on the rail corridor was in part due to the high fees to comply with KiwiRail's permit requirements. TAIC recommended KiwiRail review its permit process by working with authorities which control roads (Waka Kotahi, local authorities such as AT) and contractors who require permits to ensure the resulting requirements of contractors are practicable.



1.4 Safety operational activity - Auckland Transport

Activity update

Context

Event management reporting provides confidence that AT is

provides confidence that AT is on top of health and safety, highlights areas for improvements and training, and helps manage safety risks. Classification of risk consequences are commonly misunderstood. For the benefit of all system users, the definitions to the right have been implemented.

	injury	III-Health
Extreme (21-25)	Multiple fatalities or long- term widespread health impacts. Includes notifiable incidents with potential for outcome.	Multiple fatalities or long-term widespread health impacts. Includes notifiable incidents with potential for outcome.
Major (16-21)	LTI>14 days or life- threatening consequences and notifiable deaths. Includes notifiable incidents with potential for outcome.	Permanent disability or irreversible health problems from injury and occupational illness, unlikely to return to work with significant modifications. Includes notifiable incident with potential for outcome.
Moderate (9 – 15)	LTI> One day and up to 14 days.	A diagnosed occupational illness case and moderate, minimal, local, or non-invasive intervention indicated up to severe but not immediately life threatening.

III_Haalth

Key progress and insights

- The event management training materials are also being updated so that our employees can classify their safety events in Synergi and provide us with accurate data each day. We continue to observe misclassification around the risk outcomes for moderate to extreme risk cons.
- Safety events with a moderate risk consequence increased in February partly due to adverse weather events in Auckland, as well as our workers having interacted with the public more frequently.
- Teams are more at risk in the Service Delivery, and Customer Experience due to the fact that these teams are public facing.
- There was an increase of 20% in safety events and 61% in hazards reported compared to January.
- There was a decrease of 42% in work pain and discomfort events compared to January.
- In February, safety events identified as critical risks had an increase of 20% compared to January, from 20 events in January to 24 events in February.
- There were no safety events identified as high potentials in January and February.
- In February, Total recordable injury frequency rate (TRIFR) and Lost time injury frequency rate (LTIFR) had an increase of 10% and 15% respectively due to the increase of recordable injuries including two lost time injuries and one medical treatment in February compared to only one lost time injury in January.

Key risks

- Limited safety event reporting from all AT business units. We are interacting with these teams to better understand the factors that are preventing them from reporting and remediate.
- The Safety team is aware of numerous systems/data sources on safety events. To ensure accuracy and correct coverage we working to validate relevant safety data and collate sources.

High potential or notifiable events with a risk consequence of major and extreme

Date/Type	Event	Commentary
N/A	There are no notifiable, high potential or safety events with a risk outcome of major or extreme to report for January 2023 or February 2023.	

Dashboard

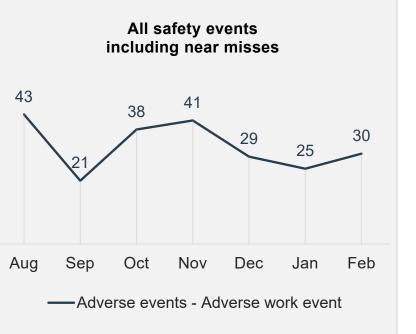
Safety events including near misses
February 2023

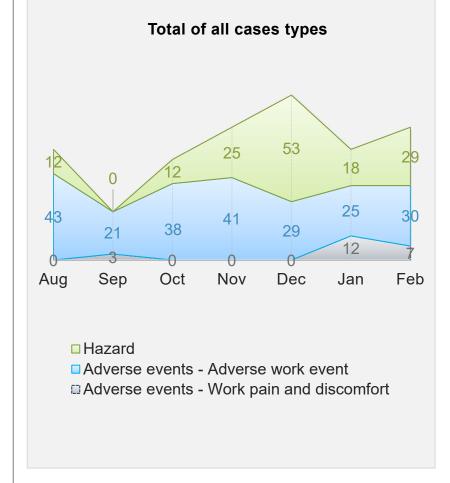
Hazards
February 2023

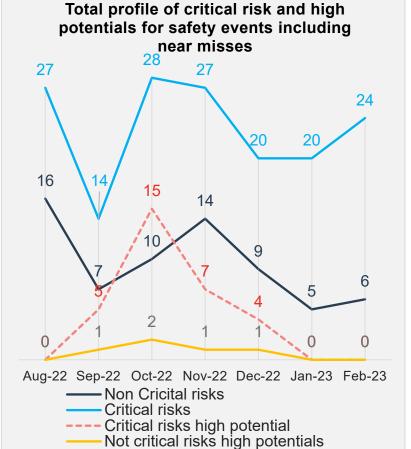
High potentials
February 2023

Safety events
with a moderate
risk outcome
February 2023

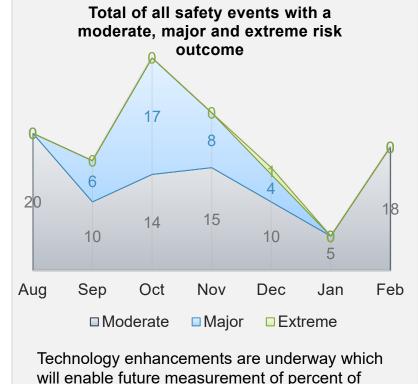
Notifiable safety events reportable to WorkSafe February 2023



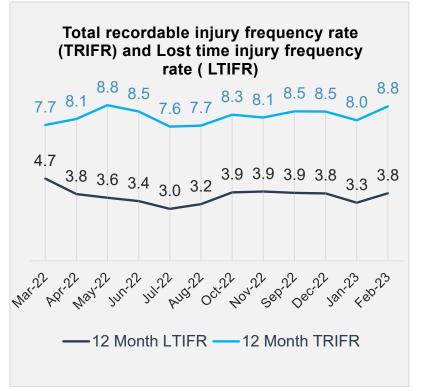








events where learning have been completed.





1.4 Safety operational activity - Auckland Transport critical risks spotlight

Spotlight

AT Critical Risks

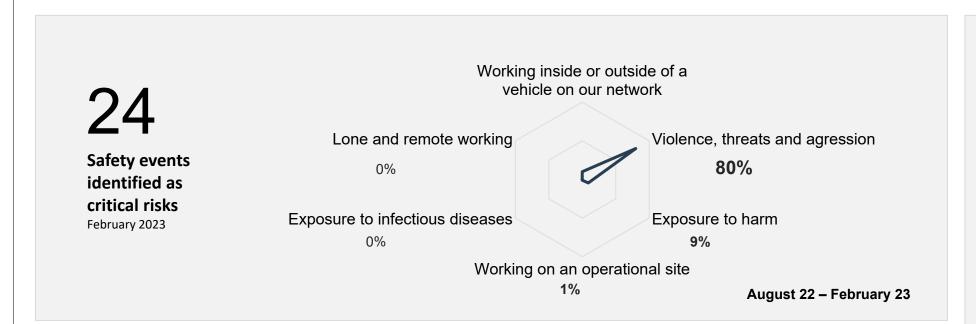
Context

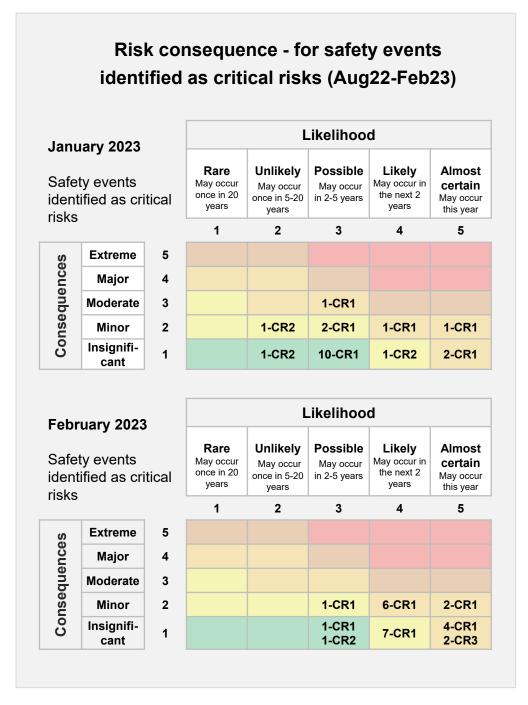
Health and safety work starts with identifying and understanding what AT's work-related health and safety risks are. WorkSafe's guidance is for businesses to focus on critical risks first before managing less serious risks.

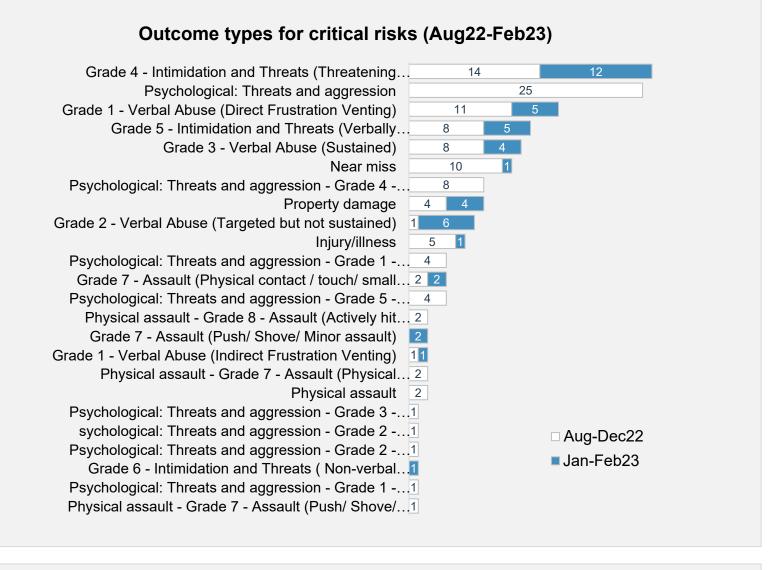
Key insights

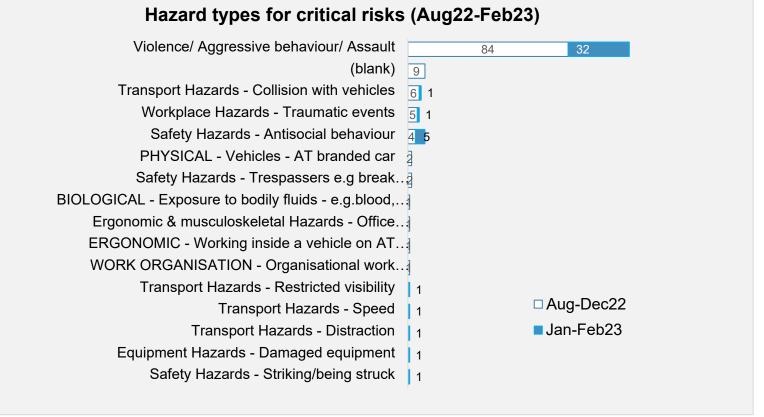
- Violence, threats and aggression (VTA)
 maintains its consistent trend from the prior
 months with 80% of critical risk events
 attributed to it, with the least number of events
 reported involving working inside or outside of
 a vehicle and being exposed to psychological
 injury.
- The outcome table shows that where VTA has happened, it typically entails verbal abuse from member of the public.
- According to the risk outcome heat map for both January and February, when a critical risk has been reported the risk outcome falls into the moderate or lower risk outcome category.
- 88% (21 of 24) of the reported events classified as presenting a critical risk to AT people were related to VTA.
- Even though AT has classified lone and remote working as a critical risk (CR6) and exposure to infectious diseases as a critical risk (CR4), no safety events have been reported against these CR from August 2022 until now.
- In February, no safety events with critical risks were classified as major or extreme risk consequence, there were eleven events classified with a risk consequence of moderate.

Dashboard











Update on key notifiable or high potential events

Context

The Health and Safety at Work Act 2015 discloses a notifiable incident as an unplanned or uncontrolled incident in relation to a workplace that exposes a worker or any other person to a serious risk to that person's health or safety, arising from an immediate or imminent exposure to several high potential events, such as but not limited to fall or release from height, collapse of structure, electric shock, collision of vessels, fire, explosions and spillages. Specific injuries and illnesses relating to a person must also be notified to regulatory bodies.

Area	Regulator	Notifiable Definition
Occupation al Health & Safety (workplace)	WorkSafe	When as a result of works being undertaken, a death, notifiable illness, injury or incident occurs.
Ferry	Maritime NZ	Accidents, incidents and mishaps reportable to Maritime New Zealand in accordance with Section 31 of the Maritime Transport Act 1994 and Section 56 of the Health and Safety at Work Act 2015
Rail	Waka Kotahi	Accidents and incidents associated with the operation of a rail vehicle, the use of the railway infrastructure or the use of railways premises in accordance to Railways Act 2005

and Health and Safety at

Work Act 2015

Key insights for notifiable events

Bus

- January: No notifiable events for bus operators
- February: Pavlovich have captured a violence, threats and aggression (VTA) event which has been recorded in Synergi as notifiable. Upon review no harm via injury or illness was caused to persons. Items such as these should be captured under our critical risk reporting structure.

Ferry

- January: All three notifiable events reported via the MS Form were also captured via Synergi which demonstrates good progress in compliant reporting.
- February: One notifiable event reported by Fullers via Synergi which was not a significant health and safety event, and no persons were harmed. The event is captured as property damage and repairs have been undertaken on the effected vessel. This event was not highlighted on the monthly report received via Fullers.
 - All four notifiable events reported are in relation the vessel safety, involving faults, breakdowns and damage due to impact. Although no persons were harmed or near harmed, it is suggested that AT undertakes some assurance activities around vessel maintenance and monitors activity for a period of time.

Rail

- January: Unusually there were only four notifiable events captured by Auckland One Rail (AOR) for this reporting cycle, which involved two anti social behaviour / assaults, one of which was an assault to a guard at Manukau station. The other two events were both related to procedural breaches, one of which was a staff member without a valid medical. An investigation is underway. The second procedural breach was a platform overrun.
- February: Out of the 15 notifiable events reportable to Waka Kotahi, three highlighted as significant
 - There were two entrapped passenger events on the same day but different occurrences, as highlighted. Follow up is required for assurance purposes. A fatality due to barrier breach is for note. In comparison to previous months, violence threats and aggression appear to be minimal for the month of February. With only two events captured, these involved members of the public and youths, no workers were harmed. There were three events with youths on or near railway line, one of which required de-energisation resulting in multiple service cancellations.

Key insights for high potentials

- February: Pavlovich captured one event identified as high potential (HIPO) and notifiable, see insights above in the bus section.
- Review of recording and reporting of HIPO's is underway, however for this cycle all HIPO's mentioned within this section are near misses. There is a requirement to review the reporting structure of said events to ensure that we clearly understand and have visibility of critical risks, passenger safety and road safety, in addition to accumulative safety, health and wellbeing concerns.

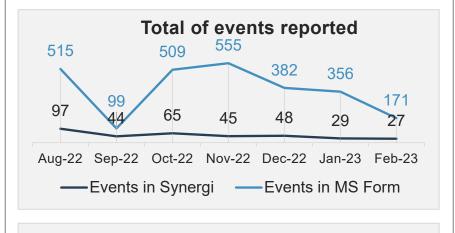
Rus

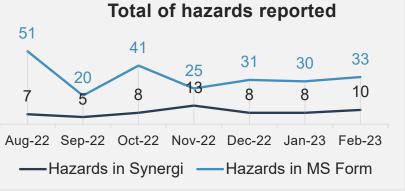
A breakdown of HIPO's for bus operators would provide us with clearer information and enable us to focus on specific areas, such as VTA events, broken down into risk to driver or risk to passengers. Additionally, many HIPO near misses are in relation to road safety, hard breaking events, near collisions, and other road users. Having this information collected and presented better will enable us to apply appropriate on-going management and oversight of safety concerns on the network, as well as aid us in working better with and supporting our operators.

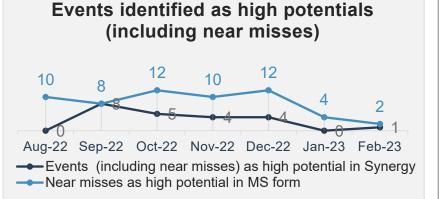
Ferry

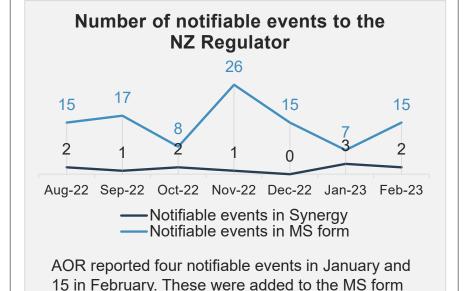
• AT and ferry operators are working together to ensure that reporting is consistent, and the required information is provided. Additionally, information provided outside of the notifiable regulations is often lacking and requires follow up for a clearer understanding of what happened end to end and assurance of ongoing management and improvements.

Dashboard









data in the graph above.



1.5 Supplier management - Public transport (PT) operators critical risks spotlight

Spotlight

PT Critical Risks

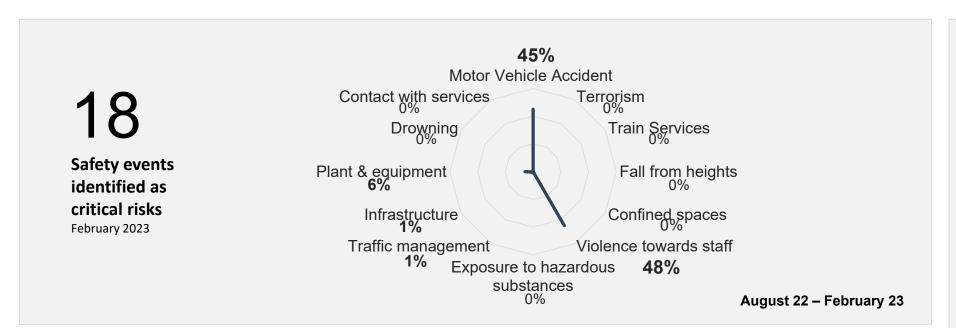
Context

Identification and management of PT critical risks is essential in ensuring our partners are operating safely, PT workers are protected from risk of harm and service users are not exposed to harm, as far as reasonably practicable. AT is working with all operators to eliminate or contain significant risks via consultation, cooperation and coordination with other persons conducting a business or undertaking (PCBUs).

Key insights

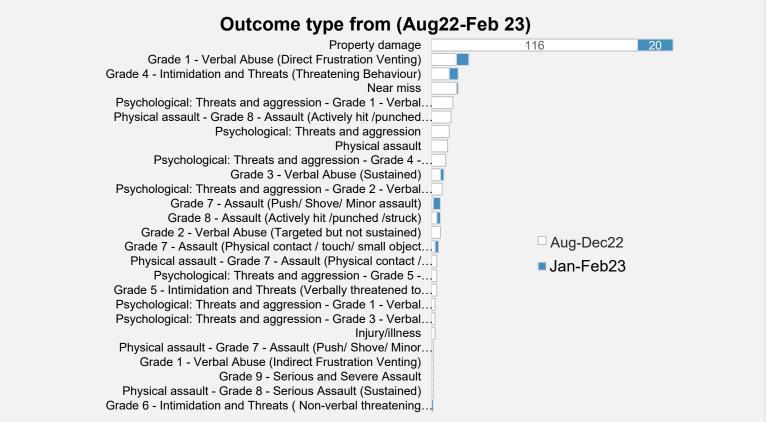
- Violence towards staff and motor vehicle accident maintain its consistent trend from the prior months with 48% and 45% respectively of critical risk events attributed to it, with the least number of events reported involving traffic management and Infrastructure.
- Property damage continue trending as the largest consequence for all safety events identified as critical risk.
- According to the risk outcome heat map for both January and February, when a critical risk has been reported the majority of risk outcome falls into the moderate or lower risk outcome category with an exception of one major risk.
- In February, there was one safety event identified as critical risks classified as major risk consequence related to violence towards staff and 10 under moderate risk consequence. Those 10 were related to: three motor vehicle accident, six violence towards staff and one plant and equipment.
- 56% (10 of 18) of the reported events classified as prese nting a critical risk to PT operators were related to violence towards staff.
- Even there are 12 critical risks (CR) identified for PT operators, there are seven critical risks that have not been reported against these critical risks from August 2022 until now involving: terrorism (CR2), train services (CR3) fall from heights (CR4), confined spaces (CR5), exposure to hazardous substances (CR7), drowning (CR11) and contact with services (CR12)
- Many of the critical risks in this category would fall under notifiable events under regulatory obligations. As reporting becomes more refined, we may see a higher number of critical risks highlighted in this space.

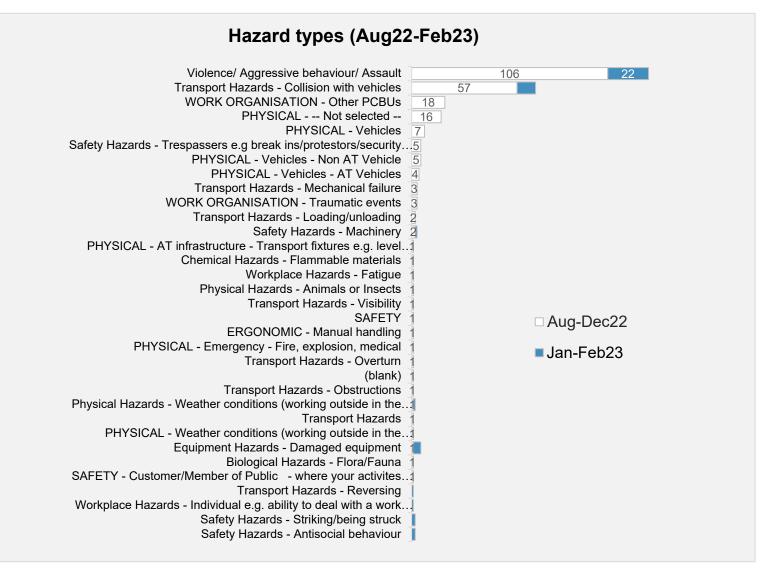
Dashboard



Work events identified as critical risks (Aug22-Feb23) 41 0 84 26 21 21 21 21 24 14 14 14 13 14 10 88 7 88 7 CR1 - Motor vehicle accident - CR6 - Violence towards staff - CR8 - Traffic management - CR9 - Infrastructure - CR10 - Plant & equipment

Risk consequence - for safety events identified as critical risks (Aug22-Feb23) Likelihood January 2023 Rare Unlikely Possible Likely Safety events May occur May occur May occur in certain May occur once in 20 the next 2 identified as critical once in 5-20 | in 2-5 years years risks Extreme Major 3-CR6 Moderate 1-CR1 2-CR6 2-CR6 Minor 4-CR6 1-CR10 Insignifi 1-CR10 1-CR10 2-CR6 1-CR6 3-CR10 Likelihood February 2023 Unlikely Possible Safety events May occur | May occu certain May occur identified as critical once in 20 once in 5-20 in 2-5 years the next 2 risks 5 Extreme Major 1-CR6 Moderate Minor 1-CR6 3-CR1 Insignifi 4-CR1 2-CR6 6-CR6 cant







1.5 Supplier management - Physical works (PW) contractors

Update on key notifiable or high potential events

Context

The Health and Safety at Work Act 2015 discloses a notifiable event as an unplanned or uncontrolled event in relation to a workplace that exposes a worker or any other person to a serious risk to that person's health or safety arising from an immediate or imminent exposure to several high potential events, such as but not limited to fall or release from height, collapse of structure, electric shock, collision of vessels, fire, explosions and spillages. Specific injuries and illnesses relating to a person must also be notified to regulatory bodies.

Area	Regulator	Notifiable definition
Occupational Health & Safety (workplace)	WorkSafe	When as a result of works being undertaken a death, notifiable illness, injury or incident occurs.

Term	Definitions
High potential event	Is classified as a situation or group of situations that has the potential to cause significant harm to person or property. These are normally viewed and approached as actual events, due to the severity rating.
Near miss	Is classified as a dangerous occurrence which could have caused harm but didn't, there is often some debate around what constitutes as a near miss and contributes to several different reporting styles throughout safety management.

Key insights for notifiable events

• There were no notifiable events reported within the physical works sector for January or February 2023.

Key insights for high potentials or near misses

- Of the six high potential near misses reported, three were in relation to violence, threats and aggression, two were plant and equipment failures, and one was unsafe behavior reported in relation to a road user breaching safety protocols whilst driving through site.
- All six near misses are of interest to AT and follow up is required for several events to gain a clear understanding of what happened. It is important that AT has visibility and or involvement in learnings from some of these events, as well as assurance that contractors are managing worksites and maintaining plant and equipment appropriately.
- Most of these events have been highlighted via the monthly report (MS form) and are not reported in Synergi. It is important that we work with AT people and contractors to ensure such events are not only reported but communicated and acted upon.
- Action is underway to follow up with AT teams to ascertain if they had knowledge of the reports submitted
 for January and February. These occurrences should appear as safety talks in weekly management
 meetings and should not be highlighted as part of a monthly data capture.

Assurance activities

Context

The assurance activities undertaken by AT project managers demonstrates our internal due diligence of construction activities and progress. We highlight live sites as this puts into context the data we receive, and the number of reports submitted via our external physical works contractors.

Key insights

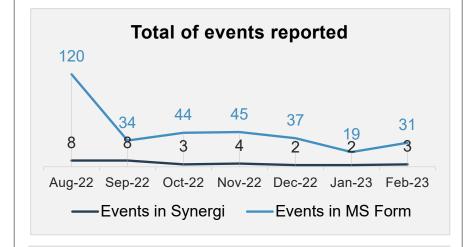
- January: We received 11 monthly health and safety (H&S) reports via the MS form, provided by nine contractors. Many of our contractors work across multiple sites, for which they provide individual reports. Going forward, we are seeking consolidation of information received resulting in contractor level reporting over project level reporting. AT project teams shall be responsible for ensuring project level safety is maintained and reported against for the purpose of ongoing contractor safety management and assurance.
- February: We received 14 monthly H&S reports via the MS form, provided by 10 contractors.

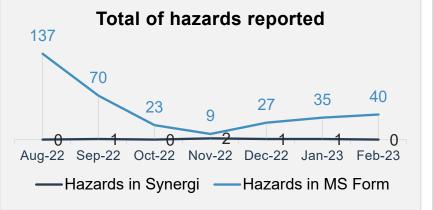
	Live	sites	Audits undertaken		
Area	Jan23	Feb23	Jan23	Feb23	
Construction	7	11	15	28	
Investigation & design	0	0	0	0	
Local and safety projects	2	10	0	5	
PT facilities & structure	5	5	3	4	

PW contractors January 2023

	February 2023
Ventia	Legacy Construction
Troy Wheeler Contracting Ltd	Fulton Hogan
Downer	Dempsey Wood
Phoenix Solutions	Wharehine Contractors Ltd
Fulton Hogan	HEB
Wharehine Contractors Ltd	Naylor Construction Ltd
Dempsey Wood	Oxcon CLL Ltd
Naylor Construction Ltd	Sansom Concrete Repairs Ltd
Mason Contractors Limited	Mason Contractors Ltd
	Phoenix Solutions

Dashboard

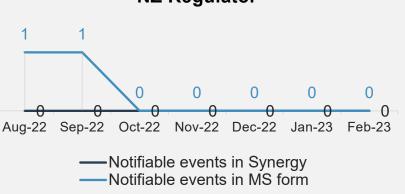






Near misses as high potential in MS form







2. Road safety dashboard



2.1 Road safety performance

Performance update

Context

One of AT's strategic focus areas is to make Tāmaki Makaurau's transport system safe through the adoption of the Safe System approach and eliminating harm. The programme is divided into four CAPEX branches of high-risk intersections, high risk corridors, speed and vulnerable road users. OPEX component include enforcement, technology (e.g. speed and red-light cameras including monitoring), education, policy and operations (e.g. CAPEX land and fees and OPEX monitoring and maintenance.

Key progress and insights

- The 2019 AT Road Safety Programme Business Case (PBC) is under review based on a wider focus of transport safety, not solely road safety, and the timing of Regional Land Transport Plan (RLTP) cycle, with the goal of delivering a full refresh by mid to end of year FY24. A first draft of the gap analysis is being evaluated by the PBC working group. The Road Safety engineering RLTP bid submitted at the end of February was alignment to the current Road Safety PBC and Road to Zero.
- AT's current statement of intent performance target for Safety are currently under review. The initial direction will be to simplify from three targets to the single metric for death and serious injuries on all Tāmaki Makaurau roads, with our longer-term vision to have no more than 250 deaths and serious injuries by 2030. This is in line with AT's Vision Zero strategy.
- Year to date, 95 people have been killed or seriously injured on our roads on Tāmaki Makaurau roads, 12 less than the same time period in 2022.
- Year to date, eight people have lost their lives on our roads. All five deaths in January were invehicle occupants; four drivers and one passenger. All died on local roads and 60% of these roads had speed zones 80kmh or higher. The three deaths in February included one driver, one pedestrian and one motorcyclist. Two died on local roads with speed zones of 50kmh.

Initiatives	Progress and insights
Katoa Ka Ora engagement and technical work	 Follow up on mana whenua requested locations Request to workshop with Transport and Infrastructure Committee Technical mapping work following local board workshops Workshops with 21 local boards
Road Safety Programme Business Case	 First draft of the gap analysis being developed by WSP is under review by the Working Group Dashboard to compare data between different systems that capture true harm is being developed so we can gather deeper insights.
Review	Risk: Complex document requires a number of stakeholders to jointly agree on the standards, requirements and resulting activities.
2023 Safety Advocacy Plan	 Drafting 2023 safety advocacy plan for March safety committee, providing recommendation on the following priorities: alcohol and drug enforcement, automated enforcement, review of motorcycle safety, and fines and penalties review.

Dashboard

deaths and serious injuries occurred on Tāmaki Makaurau roads year to date

January to February 2023
Crash Analysis System (CAS) and Ministry of Transport data*

Serious injuries

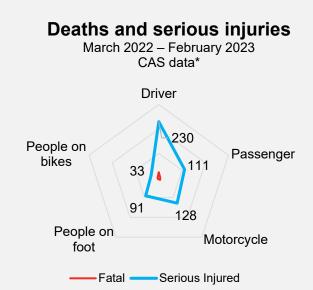
Deaths

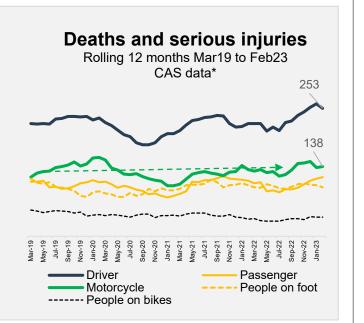
87
98
Deaths

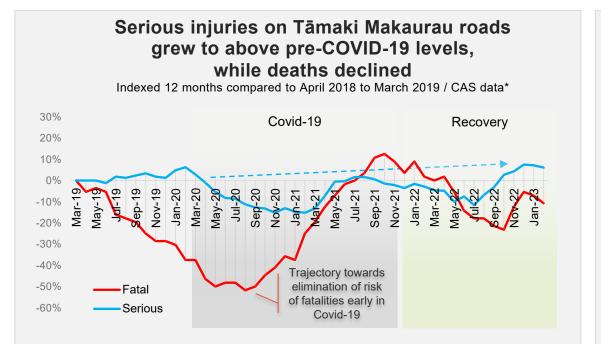
■Jan-Feb23 □Jan-Feb22

643 deaths and serious injuries occurred on Tāmaki Makaurau roads over the last 12 months. 50 people lost their lives and 593 were seriously injured. Drivers and motorcyclists remain the largest groups harmed on our roads

March 2022 to February 23 CAS data*



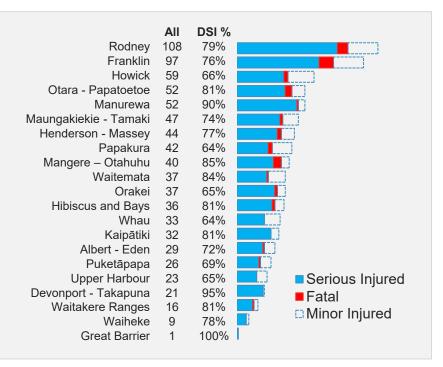


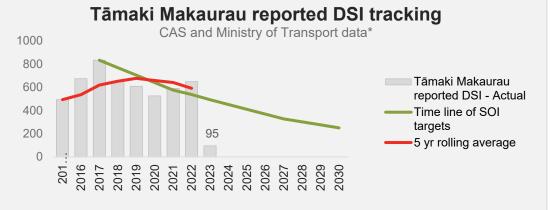


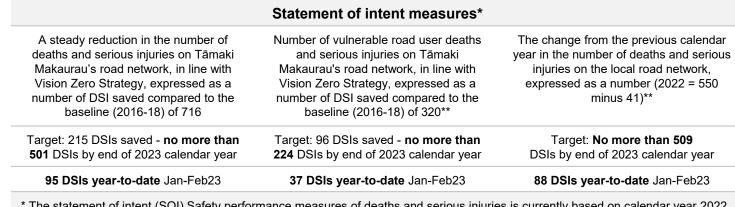
31% more injuries occurred on Tāmaki Makaurau roads when adding minor injuries from fatal and serious crashes to death and serious injuries over the last 12 months (from 643 to 841)

49% of injuries occurred in six local board areas: Rodney, Franklin, Otara-Papatoetoe, Manurewa, and Maungakiekie – Tamaki

March 2022 to February 23 CAS data*







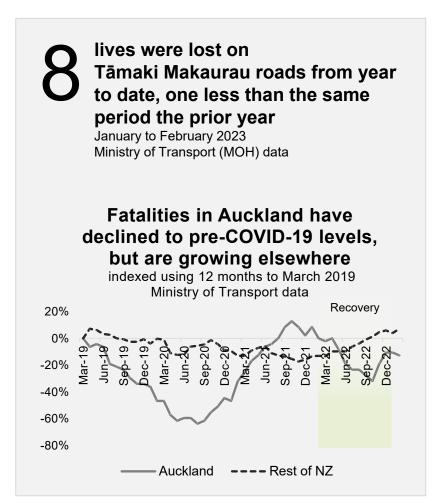
^{*} The statement of intent (SOI) Safety performance measures of deaths and serious injuries is currently based on calendar year 2022. We are currently reviewing the 24/25 – 26/27 SOI.

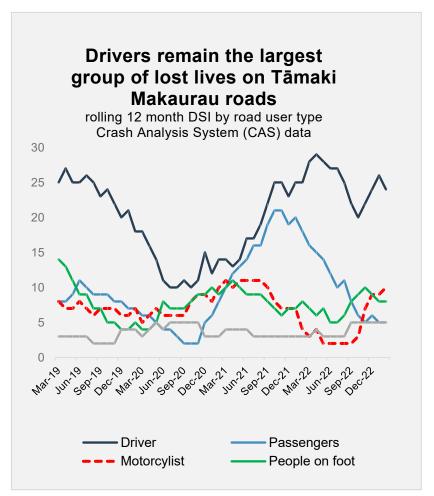


^{*} Provisional injury data for the report was sourced on 8 March 2023 noting approximately a 2 month lag in CAS data meaning that CAS values are likely to be lower than actual numbers. Deaths statistics are further sourced from Ministry of Transport which removes the lag, particularly when reporting short interval year to date figures. For SOI tracking, calculations are based on provisional data and long term trend data to give a best assessment of likelihood of meeting or exceeding targets.

2.2 Fatal crash reporting

Performance update





Period	Description of incident	Age and gender	Road user	Restraint	Speed	Local or state highway*	Urban or rural*	Causal Factors
January 2023	Glamorgan Drive The deceased vehicle crossed the centreline and collided head on with a bus.	31 year old female	Driver	Unrestrained	50 km/hr	Local road	Urban	Suspected alcohol and inappropriate speed
Road oolicing oad death	Pukekohe East Road The deceased vehicle crossed the centre line after rounding an easy right bend Infront of an oncoming truck and collided in an offset head on collision. MoH as not in CAS yet.	72 year old female	Driver	Restraint unknown	80 km/hr	Local road	Open	Unknown
notifications	Porchester Road The deceased was travelling in a seven person people mover. The people mover crossed the centre line and collided in an offset head on collision with a cab truck.	One year old child	Passenger	Unknown if in appropriate	50 km/hr	Local road	Urban	Suspected alcohol and inappropriate speed
	South Head Road A sports utility vehicle (SUV) crossed the centreline and into the path of the deceased vehicle causing a head-on collision.	74 year old female	Driver	Restrained	100 km/h	Local road	Open	Suspected alcohol, drugs inappropriate speed
	Awhitu Road The deceased vehicle veered rightward across the road before striking a dirt bank and rolling. Unrestrained, ejected from the vehicle and landed on the road.	18 year old female	Driver	Unrestrained	80 km/hr	Local road	Open	Suspected alcohol and inappropriate speed
ebruary 1 023 Road	Glenview Road The deceased had run across the rail track in front of a moving westbound train. He was caught up under the train and died at the scene. From MoH as not in CAS yet	75 year old male	Person on foot		50 km/hr	Local road	Urban	Unknown
policing road death notifications	Hillsborough Road The deceased vehicle had veered off the road into a pedestrian crossing pole	52 year old male	Driver	Restrained	50 km/hr	Local road	Urban	Unknown
	State Highway The deceased motorcycle clipped the rear left corner of a vehicle and caused the motorcycle to fall on its left side, into the left lane and was driven over by an oncoming double decker bus.	19 year old male	Motorcycle		100 km/hr	State highway	Open	Unknown

AT Road Safety Engineering team reported actions Road Safety Engineering fatal crash reports							
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- There remains one action in progress from 2019, one open from 2021, 10 open in 2022 and 2023 reports are yet to be finalised
- Fatalities investigated by the AT Road Safety
 Engineering Team may be less than the number of
 deaths reported by CAS and MoT due to the timing of
 confirmed deaths and if there was more than one death
 in one fatal crash. At the time of this report, four local
 road deaths out of seven

Local road fa	atal crash reporting as reported in CAS		
Safe System	Metric	Year-to-date Jan-Feb 2023 insights	2022 calendar year insights
Roadside	Road star rating summary	Waka Kotahi Mega Maps tool is being updated and not available until April 2023	• 2.71 is the average safety rating of roads on which fatalities have occurred in 2022
	Involved unprotected roadside hazards	40% of the five fatalities involved an unprotected roadside hazard	67% of the 38 fatalities involved an unprotected roadside hazard
	Involved vulnerable road users (VRUs) with insufficient infrastructure	0% of VRU fatalities occurred where there weren't primary treatments	100% of VRU fatalities occurred where there weren't primary treatments
	Urban locations with non-primary safety treatments	33% of urban FCRs occurred at locations without primary safety treatments	All urban FCRs occurred at locations without primary safety treatments
Speeds	Percentage of fatal crash reports (FCRs) on roads with safe and appropriate speeds (SaAS)	 60% of the five fatalities occurred on roads where the posted speed limit isn't aligned to the SaAS 	the SaAS
		 SaAS have been proposed on four roads during phase three therefore not yet implemented 	 SaAS have been proposed on four roads during phase three therefore not yet implemented
	Percentage of FCRs where speed limit exceeded	0% of the five fatalities involved a vehicle exceeding the posted speed limit	50% of the 38 fatalities involved a vehicle exceeding the posted speed limit
Vehicles	Vehicle star rating summary	 The average vehicle star rating of vehicles containing fatalities or involved with VRUs is 3.8 stars 	 The average vehicle star rating of vehicles containing fatalities or involved with VRUs 3.3 stars
	Vehicles with warrant of fitness (WoF)	 20% (one) of the five fatalities involved a vehicle without a valid WoF 	39% of the 38 fatalities involved a vehicle without a valid WoF
	Number of FCRs involving public transport operators	20% (one) of the five fatalities involved public transport operator	• 5% (2) of the 38 fatalities involved public transport operator
Road users	Alcohol	0% of the five fatalities have alcohol above legal limit confirmed as a causation factor	• 44% of the 38 fatalities have alcohol above legal limit confirmed as a causation factor
	Restraints	0% of driver/passenger fatalities involved non-use of restraints where available	22% of driver/passenger fatalities involved non-use of restraints where available
	Distraction	0% of the fatalities to date have noted distraction as confirmed or suspected.	11% of the fatalities to date have noted distraction as confirmed or suspected.
	Learner/ restricted Licensing	 40% of the five fatalities involved a party with a learners license. 20% of the five fatalities involved parties with restricted licenses 	• 17% of the 38 fatalities involved a party with a learners license. 28% of the 38 fatalities involved parties with restricted licenses

