ANATOMY OF AN OBJECT FALL FROM HEIGHT INCIDENT

Awareness Program Training (v3.1 25/02/2024)

Trainer Name:

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

MOVE BEYOND


WELCOME
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WELCOME MESSAGE

"Welcome to the Anatomy of an Incident (Object Fall from Height) Awareness Training.

This training is one of the most important safety initiatives that we as a business have done. It is important for 2 reasons.

Firstly, this training is to be delivered to all field employees as part of an Enforceable Undertaking that TK Elevator has entered into with Worksafe Victoria following an Object Fall from Height incident that occurred on one of our Modernisation sites in Melbourne on 19th May 2020. During this incident, a 2kg test meter being used by a Sub-Contractor on the top of an elevator car to test and tag portable electrical equipment fell over the side of the car that was positioned on the 13th floor. The sub-contractor on the car was being supervised by a TKE employee. The test meter fell and grazed another TKE employee who had gone to the pit. The test meter glanced the employee's back and the back of his leg. Fortunately, the test meter did not land on or hit the employee's head directly and the employee in the pit was not seriously injured. Following the incident, TK Elevator self-reported the incident to Worksafe Victoria as a Dangerous Occurrence or Serious Near Miss which we were required to do under the WHS Legislation. Following their investigation, Worksafe Victoria commenced proceedings against TKE for two breaches of the WHS legislation. Employers can be charged with WHS breaches for serious near misses even if no one is actually killed or seriously injured. An Enforceable Undertaking is an alternative to a prosecution being undertaken by the Regulatory Authority against an employer or business. Your attendance at this training is one of those initiatives that TK Elevator has agreed to complete.

Secondly and most importantly, your attendance at this training will hopefully prevent these events from happening again and may save your life. This was a serious close call. There was a matter of centimetres or inches between this being a serious near miss versus a fatality or serious injury to one of our employees.

Most incidents occur because of multiple failures in systems, processes and procedures. This training will take you through the incident in detail and the many contributing factors that resulted in this incident occurring. The cause of this incident is much more than just a communication breakdown between our employees and the sub-contractor on the day or employees working above and below each other in the lift shaft. The contributing factors extend back to many months before the incident occurred and include systematic failures on behalf of the organisation in terms of contractor engagement and management, task planning and risk assessment. We can best prevent these events from happening again by understanding the system and organisational failures that contributed to this incident and improving our processes so we can mitigate the risk of objects falling from height and the hazards of people working above and below each other in the lift shaft.

Thank you again for your attendance to this training. Your contribution throughout the training will increase our level of safety engagement and awareness and your participation will ensure that you and other people you work with, get home safely to your families and friends".

David Husoy
Managing Director – TK Elevator Aust & NZ

OUTCOMES WE ARE AIMING FOR

Attendance to this Training Course is mandatory. The outcomes we are aiming for are:

1. An awareness of the incident, the root cause and contributory factors of the incident and an analysis into why (existing) controls failed to prevent the incident from occurring.

2. Development of skills and knowledge in the Incident Cause Analysis Method (ICAM) and the ‘Swiss Cheese’ Model of incident causation.

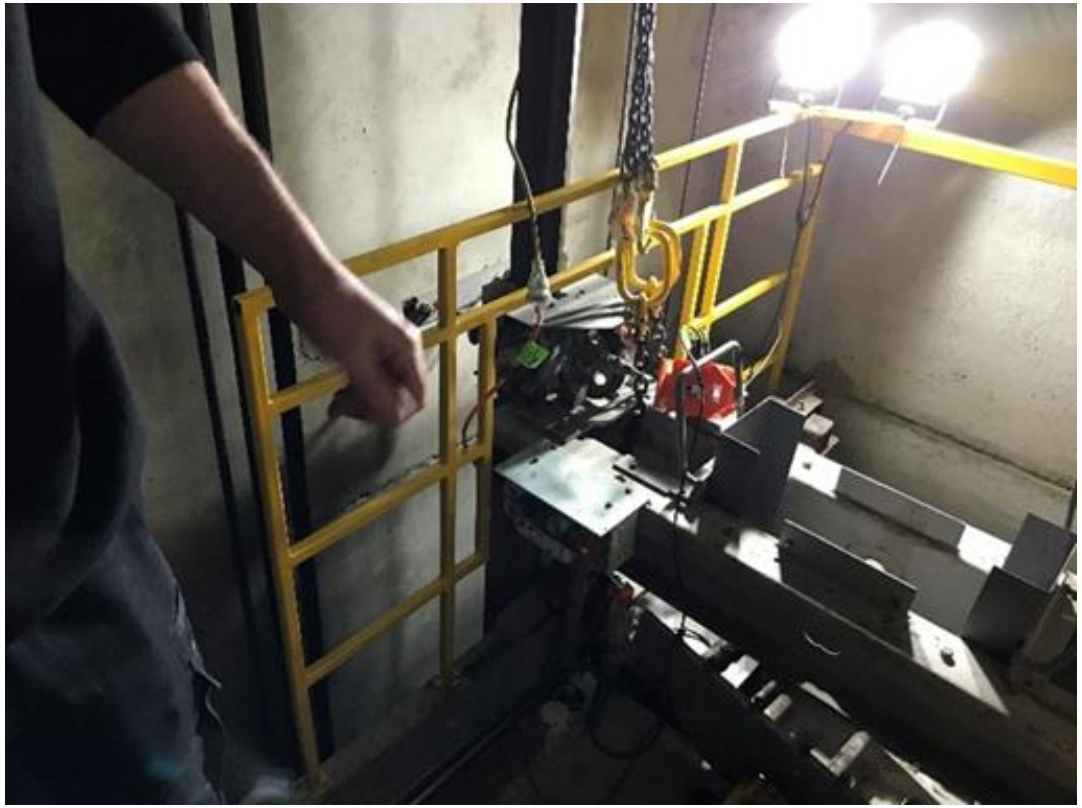
3. Confidence in the TKE safety standards that are set and in the role that Trainees ‘play’ in managing, monitoring, and maintaining TKE safety standards for incident prevention and compliance.

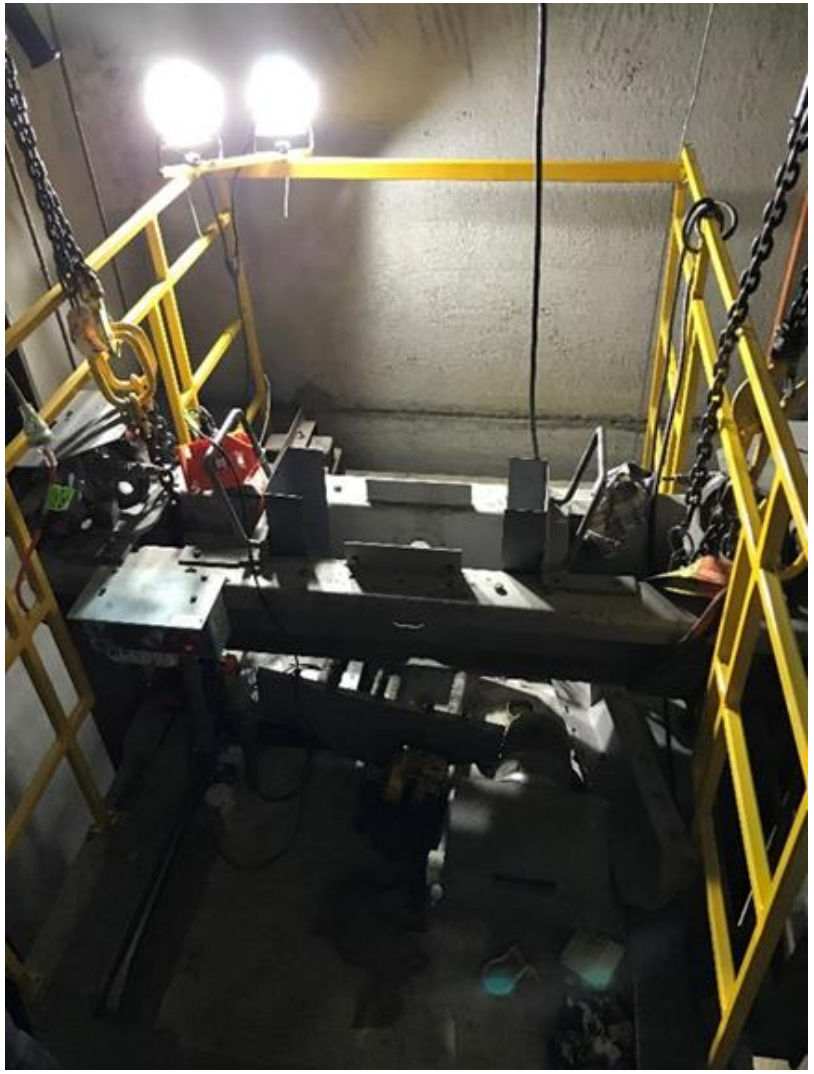
4. Confidence in the role that Trainees ‘play’ in maturing the TKE organisational safety culture.

5. Personal growth via the development of an Individual Safety Culture Action Plan (SCAP).

TOPIC 1 – AWARENESS OF THE INCIDENT

CASE STUDY – PART 1





CASE STUDY – PART 1

REFLECTION

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

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

TOPIC 2 – KNOWLEDGE OF ICAM AND ‘SWISS CHEESE’

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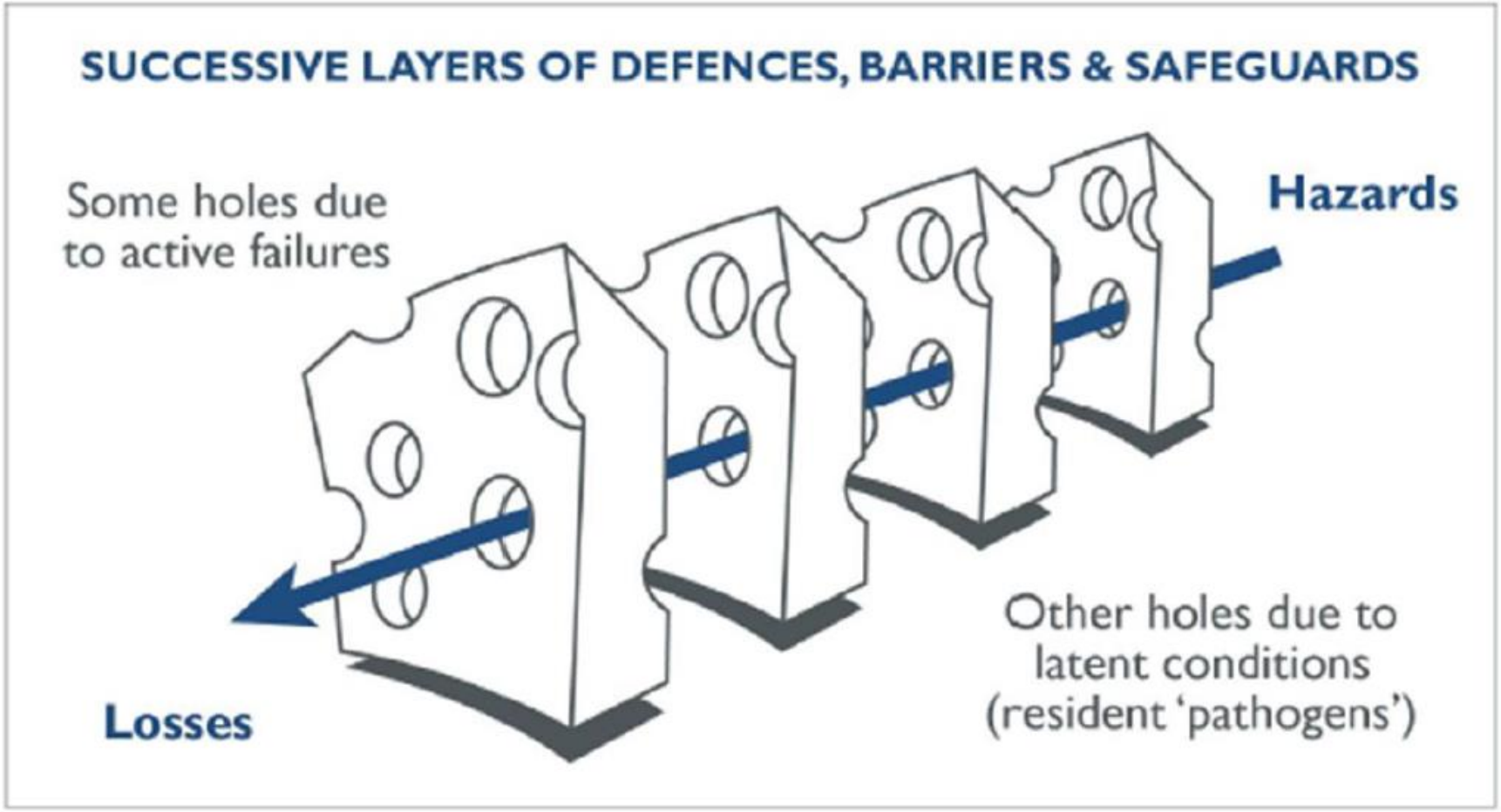
THE ‘SWISS CHEESE’ MODEL OF INCIDENT CAUSATION

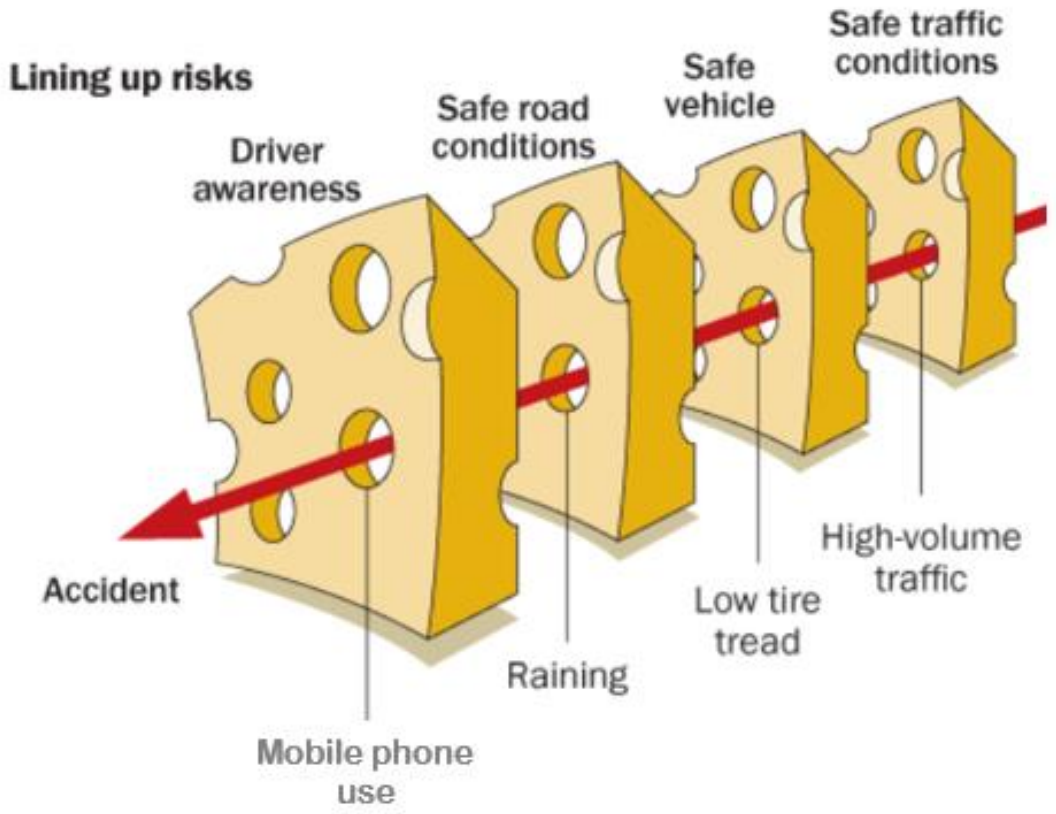
The Swiss cheese model is widely accepted by WHS professionals and has formed the basis of the Incident Causation Analysis Method (ICAM) method of Incident Causation.



SWISS CHEESE MODEL-EXAMPLE

Safety Nets:

- Fitness to drive & fatigue
- Licence & competence
- Maintenance and inspection
- Stable parking
- Segregation & access control
- Positive communication
- Secured loads
- Vehicle specifications & fit for purpose
- Driving rules



- *Multiple barriers – defence in depth*
- *Prevent active errors*
- *Detect & correct latent system weaknesses*

HUMAN FACTORS OF INCIDENT CAUSATION

Individual Factors:

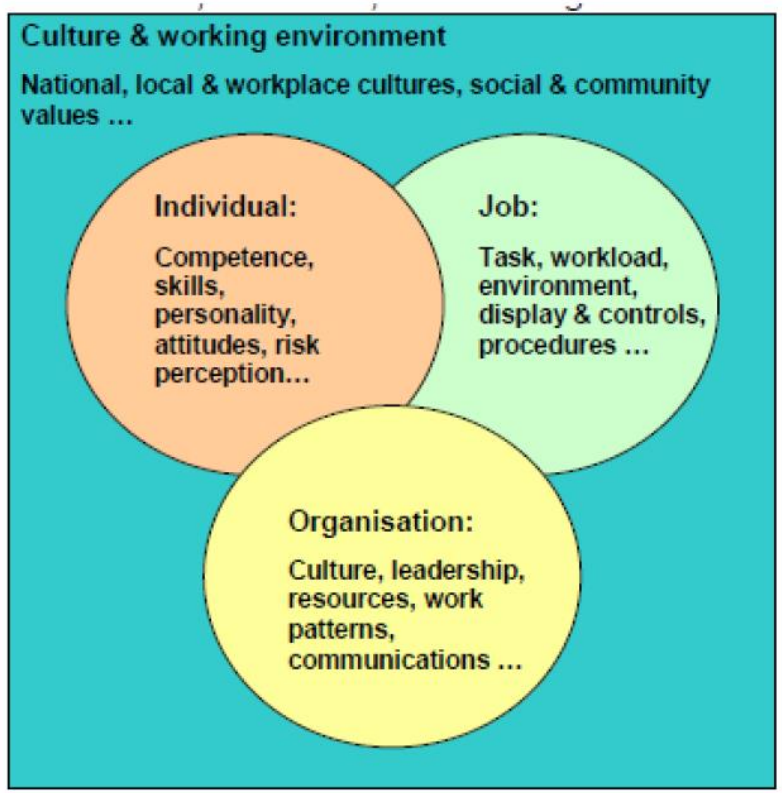
- Low skill & competence levels
- Lack of motivation
- Individual medical issues

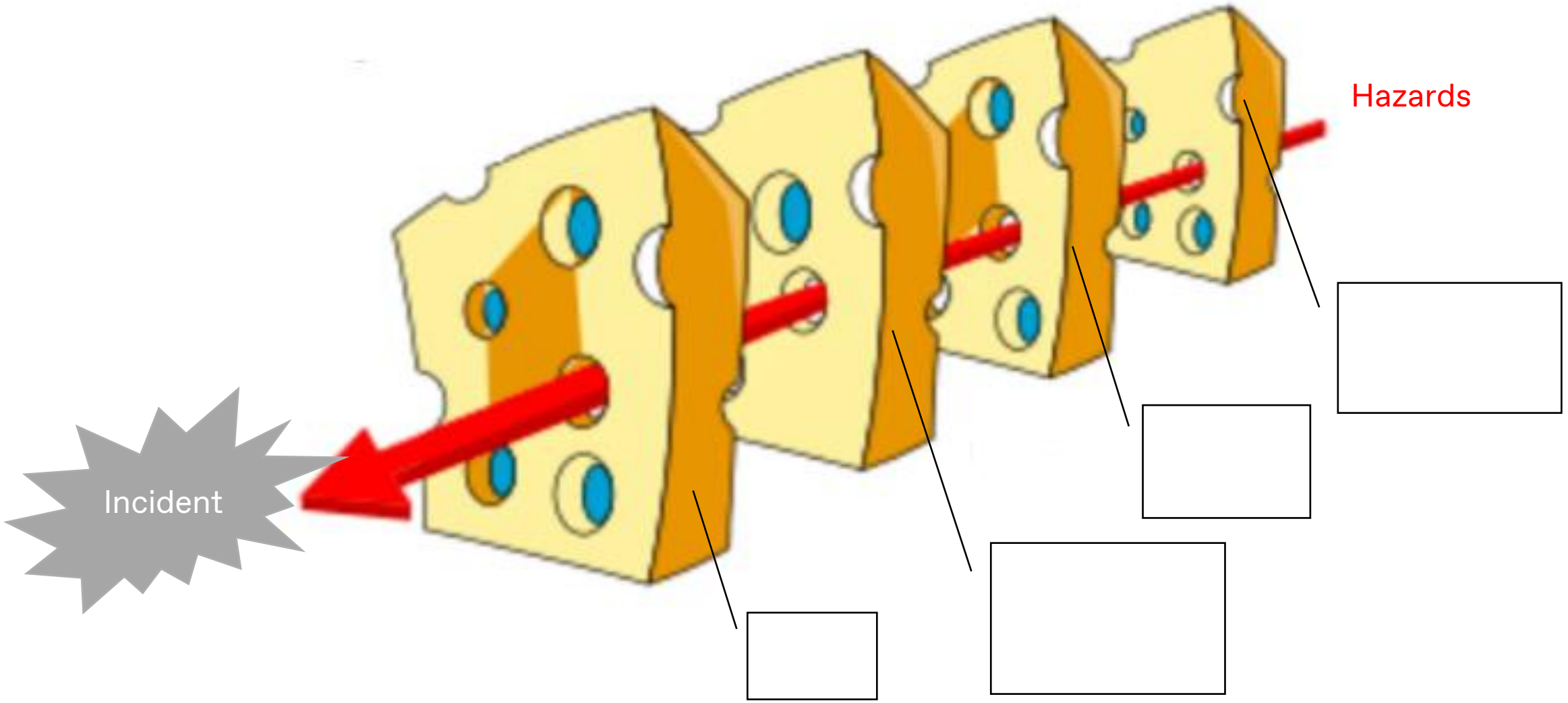
Organisational Factors:

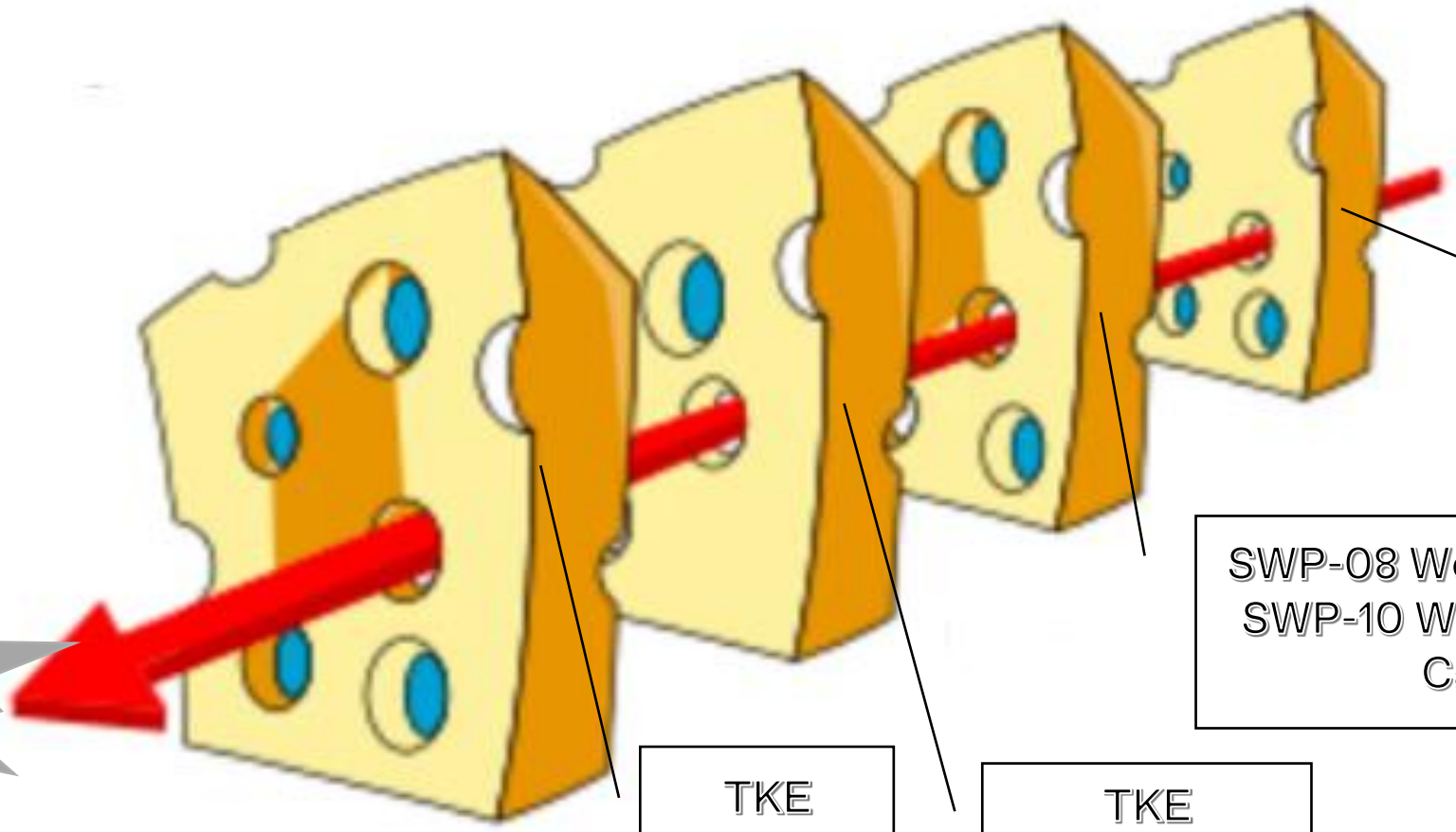
- Poor work planning
- Lack of safety systems & barriers
- Poor health and safety culture
- Deficiency in coordination of responsibilities
- Inadequate responses to previous incidents

Job Factors:

- Illogical design of equipment
- Missing or unclear instructions
- Poorly maintained equipment
- High workload
- Unpleasant working conditions




Hazards
Incident



Hazards

Equipment & Engineering Controls

SWP-08 Working at Height
SWP-10 Working on a Lift Car Top

TKE Contractor Management Procedures

TKE GSM / 10 Safety Rules

Incident

TOPIC 3 –THE POWERFUL SIX QUESTIONS

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THE POWERFUL 6 QUESTIONS

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

- The Powerful 6 Questions Support:
  - The TK Elevators Incident Management, Investigation and Reporting Procedure
  - The TK Global Safety Standards
  - TKE Lift Shaft Safety
  - TKE SWP-08 Working at Height
  - TKE SWP-10 Working on Top of a Lift Car
- The TKE Vision of all TK Elevator people actively managing and “owning” safety.

TOPIC 5 – INDIVIDUAL SAFETY CULTURE ACTION PLAN

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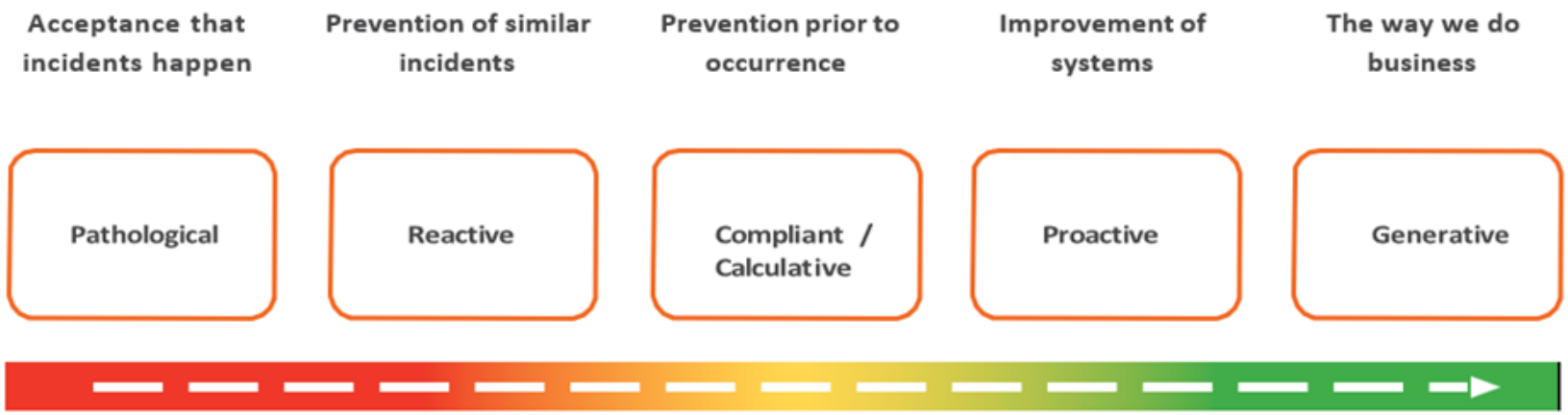
MATURING A SAFETY CULTURE

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



Progress from one level of maturity is an outcome if:

- **Leaders are increasingly informed.**
- **With increasing trust/accountability**

INDIVIDUAL SAFETY CULTURE ACTION PLAN

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

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

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THANK YOU

Please complete the Feedback Form before you leave: