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Safety Week Toolbox Talk

Safety Culture

How to use this pack

Target audience: Leaders and their teams, including contractors.

Purpose of the Toolbox Talk Pack:

- Discuss what does ‘Culture’ and ‘Safety Culture’ mean to your team.
- Discuss the importance of a positive (mature) safety culture.
- Discuss the characteristics of a strong positive safety culture.



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What is Safety Culture?

Safety Culture is the shared values, beliefs, attitudes and behaviours that determine how people think about and manage safety every day, particularly when no one is watching.

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A strong safety culture exists when accountability is shared, from frontline workers to senior leaders, and shows up as:

- Consistently identifying hazards
- Managing risks
- Verifying critical controls are present and effective
- Speaking up about concerns, and
- Learning from experience
- Everyone genuinely believes safety matters



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Why is a strong safety culture important?

A strong culture of care, where everyone feels safe and empowered to speak up, and where learning and improvement is valued and promoted, drives better outcomes.

Leaders play an instrumental role in influencing culture, they set the tone for what's important, how things get done, the standards expected, and they role model, through their behaviours that the safety of their people should always comes first.

Q **Discuss what type of Safety Culture you think exists in your team or work location.**

Q **What can you do to positively influence your workplace culture?**



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Characteristics of a strong (mature) Safety Culture

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01
Visible leadership commitment

- Leaders consistently demonstrate that the safety of their people is of the highest importance and underpins the way we work.
- Supervisors and managers spend time in the field discussing safety and enable safe work.
- Decisions balance production, cost and safety, with safety never being compromised.

02
Psychological safety and open communication

- Workers feel comfortable speaking up about hazards, mistakes and concerns.
- People can challenge unsafe decisions regardless of position or seniority.
- Bad news travels quickly without fear of blame.

03
Reporting and learning culture

- Near misses, hazards and incidents are actively reported.
- The focus is on learning and improvement rather than finding someone to blame.
- Lessons learned are shared across teams and sites.

04
Accountability at all levels

- Everyone understands their role in managing risk.
- Accountability applies equally to leaders, supervisors, contractors and workers.

05
Strong risk management

- Hazards are identified before work begins.
- Work involving Fatal Risks receives the greatest attention.
- Critical controls are clearly defined, implemented, checked and verified as being present and effective.

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06
Workforce engagement

- Workers are involved in risk assessments, investigations and improvement initiatives.
- Frontline knowledge is valued and used to improve work processes.
- Safety is done *with* workers, not *to* workers.

07
Trust and respect

- There is mutual trust between leaders and the workforce.
- People believe leaders will act on reported concerns.
- Commitments made are followed through.

08
Continuous learning and improvement

- The organisation constantly looks for ways to learn and improve.
- Field Leadership learnings, investigation finding reviews, audits and inspections lead to meaningful action (SMART Actions).
- Successes and failures are both recognised and used as learning opportunities.

09
Chronic unease

- People remain alert to the possibility of failure even when performance appears good.
- Absence of incidents is not mistaken for absence of risk (or mistaken for the presence of safety).
- Staff continually ask, *"What could go wrong?"* and *"How do we know our controls are working and if they are enough?"*

10
A just culture

- Honest mistakes are recognised as part of the normal human conditions and treated differently from reckless behaviour.
- People are respected and treated fairly following incidents.
- Investigations seek to understand system weaknesses and the conditions that influence how work is performed, and do not focus on ‘blame’.

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Q

Discuss these characteristics and which ones are most visible to the team.

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