

# Proactive Safety Leadership



## Implementing a Safety Campaign Take 5

# DS Smith: Leadership In Action

Working with Chris Murray, then MD Packaging UK & Ireland, we developed the Leadership in Action methodology.

- Chris was an inspirational Leader, demonstrated exceptional role modelling
- We believed that creating a 'Zero Harm' vision [that everybody believes in] and reflects the opportunities to reduce risk every day was key to engagement
- Aligned to DS Smith values, we felt it important to create an environment where it is safe to challenge and be challenged
- Safety became the responsibility of the organisation's leadership and they now owned it. Safety professionals were no longer accountable. Instead, they provided advice and guidance.
- Engagement and empowerment throughout the organisation at all levels was promoted and encouraged.
- We created a problem-solving capability enhanced and with this resilience to react to unintended consequences.
- Asset management, namely reliability, played an equally important part in the success of Leadership in Action. It's not all about safety



*"My focus was to reduce risk, every day....Zero Harm is only relevant today"*

*Chris Murray,  
Former MD Packaging UK & Ireland*

The Leadership in Action Menu (or tools / techniques) consisted of:

- Safety Share
- Safety Interactions
- Safety Improvement Every Day
- Safety Barometer
- Take 5- **Stop And First Evaluate the Risk**
- Critical Control Monitoring Plans (CCMP)
- SPI/Injury Review
- SPI/Injury Follow Up
- Senior Leadership Working Menu

# Leadership in Action Toolkit



## Example of a Safety Share

**Who: All meeting organisers**

**Topic: Double ended crow/pry bars**



**Risk:**

These are inherently hazardous tools that we use on some of our sites. Incidents have occurred where the tool has slipped and the end not in use has struck the operator resulting in injury. One incident at a previous site resulted in a mechanic slicing off his nose



**Action:**

Remove tools from site by replacement or modification (with authorisation from an engineer).  
Implement procurement controls.

## Who: All leaders

## What is a safety interaction

A simple process aimed at:

- Observing behaviours and conditions in the workplace
- Engaging people in a discussion about HSE
- Securing agreement to work in a safer and more effective way if necessary

Based on:

- Recognizing and reinforcing safe behaviours and conditions
- Identifying and correcting at risk behaviours and conditions before an injury occurs
- Providing a mechanism for problem solving and finding hidden risks so they can be eliminated
- Following up and providing feedback

**Who: All leaders**

**Why do we do Safety Interactions?**

To gain commitment from people to practice safer behaviors in a way that:

- Demonstrates line managers commitment to safety
- Supports and recognises safe behaviors
- Reinforces standards
- Identifies where people take risks
- Raises awareness of safety issues
- Identifies safer ways of doing work



## Feedback and Discussion

- Did they welcome the interaction?
- Did the person do most of the talking?
- Did they identify the risks?
- Did they identify ways to prevent incidents?
- Did I provide recognition for or reinforce desired behaviours?
- Did the person commit to change to desired behaviours?
- Will I be able to recognise those changes?
- Did I thank them and give praise?
- **ALWAYS END ON A POSITIVE**



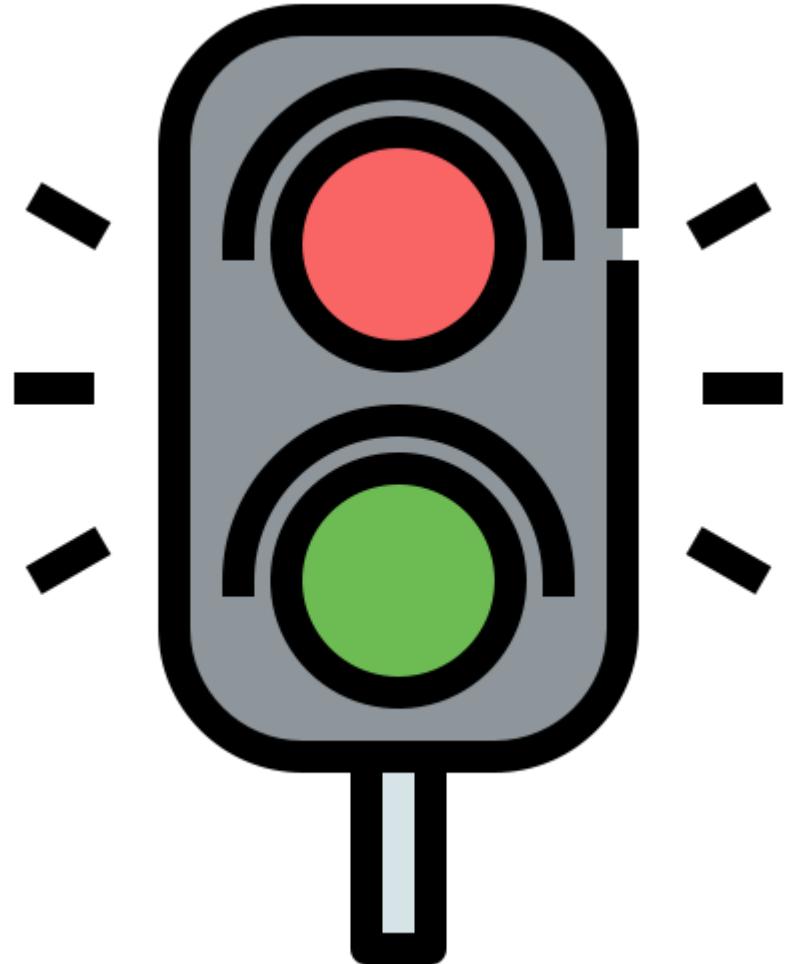
# Safety Improvement Every Day

- Excellent way to promote reducing risk every day
- Must be a sustainable improvement
- Must avoid business as usual 'tidying up'
- Use safety cross to record progress
  - Red = incident/injury
  - Green = no incidents
  - Blue = safety improvement implemented.

The safety cross must drive the improvement and not just record them.

It's not what have we done that we can put on the cross, it's what are our EHS issues today, what are we going to fix.

1	2				
3	4				
5	6				
7	8				
25	26				
27	28				
29	30				
31					



A subjective, collective decision on escalating the unease of the site due to incidents, new risks, or risks that have just been identified

## Who: Shop Floor Employees, Contractors and Visitors

### Why do a Take 5?

- Provides a disciplined and structured approach to the process
- Encourages a more dynamic assessment of the hazards
- Assists with the quality of hazard controls identified
- Allows for feedback to be provided by leaders / team members, personnel involved in Safety Interactions etc.
- Documented Take 5s should be conducted because we all recognise the value it adds for our personal safety

## When should we do a Take 5?

A TAKE 5 must be completed at the start of each shift out in the work area and prior to a change of task which could introduce new hazards

The TAKE 5 must be reviewed after each break – it is a live document

The goal is to have everyone present on the shop floor performing documented TAKE 5's every day.



### **Stop think through the task**

**This step requires us to visualise what we are about to do.**

Ask yourself :-

- ▶ Do I clearly understand what is required?
- ▶ Am I trained to do the work and familiar with the equipment / task(s)?
- ▶ Are the tools and equipment in safe condition?
- ▶ Do I have approved documentation for the task?
- ▶ Am I safe from other activities / tasks in the area?
- ▶ Have I informed others who may be affected by my work?
- ▶ Do I have the correct PPE for the task?

- ▶ **If you answer NO, STOP the task and take action to correct**

## Identify Hazards

- **RED ZONE** is any situation or person that presents or imposes an unacceptable level of risk
- For example:
  - Where **uncontrolled release of energy** can cause personal injury due to **proximity** of a hazard
  - Where **changes** in work environment can introduce **new hazards**
  - Where **physical or emotional** state can make even simple tasks hazardous (eg fatigue, stress)

## Make the changes (Controls)

Proceed and do the job safely

- Sign off the Take 5
- Everyone happy the hazards are controlled
- Let's go



## Who: All leaders

## What is a Critical Control Monitoring Plan

We tasks that have critical risks at all of our sites:

- Working at heights
- Working with moving machinery
- Working on electrical systems

All these tasks have controls be it guards, LOTOTO procedures, fall protection, training, etc.

A critical control monitoring plan is a systematic check that those controls are in place and working robustly.

[Critical Control Monitoring Checklists created to support the task](#)

## Example Check list

Critical Control Monitoring		
Task:	Name:	
Physical Location:	Date:	
Site:	Time:	
		
Fall from Height		
Fall Protection System		Compliance
1. Has a working at height permit been completed by the working party?		<input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="N/A"/>
2. Has the working party inspected harnesses prior to use? Current tag, any wear/damage to webbing/stitching, cleanliness etc.		<input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="N/A"/>
3. Has the working party inspected all of your fall protection equipment prior to use (e.g. lanyards, connectors, anchor points, safety latches, shock absorbers, retractable lanyards, 360deg swivels)?		<input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="N/A"/>
4. Is your selected fall protection equipment adequate for the task?   Check: rating, load restraints, current tag, any damage, cleanliness etc.		<input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="N/A"/>

**Significant Potential Incident:** An incident for which it is reasonably foreseeable that it could have resulted in a fatality or disabling injury.

**Requirements:**

Root cause investigation completed and presented within 2 weeks.

Incident investigation should be led by line leadership.

**Root Cause Investigation training can be provided to support**

## Who: All leaders

A visual live plan of activities to be completed

A T-card system to ensure visibility and an easy reckoner

To be reviewed on the daily meeting

Move to a technology solution is recommended after the habits have been formed to focus on responsibilities each day



**Komishibai board and T cards**

# Leadership in Action Roadmap

WHERE WE ARE?	Shop flooring	Ownership of Safety	LIA Elements	Daily Action Centre		HSE Interaction		Take 5	
				Execution	Competencies	Execution	Competencies	Execution	Competencies
Level 4 Outstanding	improvements are identified by each member of the team consistently and Actions to address improvements are completed consistently.					HSE interactions are regularly analysed to identify trends and concerns. This has led to significant improvements on site.	All levels of the organisation are competent to and regularly perform HSE interactions.	Leaders promote hazard identification process in carrying out Take 5 for themselves on a regular basis.	
Level 3 Target	All operational leaders spend at least one hour per day focusing solely on HSER on the shop floor. Shop floor is spent interacting with employees and coaching all levels of the organisation. Improvements are identified by each member of the team consistently and Actions to address improvements are completed about 50% of the time.	All operational leaders are trained and competent to perform incident investigations, write and review risk assessments and safe systems of work. Leaders involve the wider team in these tasks.	All SPI's and injury incidents are investigated in PSC and actions closed in a timely manner. Take 5 and interactions are embedded daily. Safety improvements are made every day through the safety cross. Critical control monitoring plans include critical controls that are site specific and may relate to newer SPI's or newly implemented controls. Working men's are living documents that all leaders understand the elements and concept of leadership in action.	The meeting is valued by all members of the team and provides the GM with all the information to understand the current performance of the site. Action is taken each day to address issues raised. The DAC identifies areas that require focus and drives improvement actions in those areas.	All subject leaders and the Site GM attend the Daily action centre as a routine. Each member of the team is able to lead the DAC.	HSE interactions are conducted by all leaders including contractor leaders. Interactions are planned to consider high risk activities, 24/7 work roster, cover, blackspots and include contractors.	Leaders including front line supervisors are all trained and have developed competency to conduct a quality interaction.	All operational employees and contractors are involved in a Take 5 on a daily basis.	All Employees are trained in Take 5.
Level 2 Unsatisfactory	Site leaders spend time on the shop floor each day. This is unstructured and focused on HSER amongst other things. Some time is spent interacting with employees on safety, identifying HSER improvements is not the norm and improvements identified often go unactioned.	Most Operational Leaders are trained to carry out Incident investigations, risk assessments and write and review safe systems of work. Leaders are involved in 50% of these activities on site.	Disciplines are known, but compliance is average. A planned audit for improvement is completed about 50% of the time. Leaders don't complete safety interactions on a daily basis. Each employee does not participate in Take 5 on a daily basis and it is often a tick box exercise. Leadership working menus are updated intermittently.	The DAC contains all of the listed subject areas including all communicated HSER DAC.	All subject leaders and the Site GM attend the Daily action centre as a routine. The meeting is led by the same individuals each day.	HSE interactions are mainly performed by the senior leaders on site and not front line leaders.	Leaders and front line supervisors are able to perform an interaction.	Take 5 are performed by more than 50% of shop floor employees.	Managers, front line supervisors and employees are able to perform Take 5.
Level 1 Unacceptable	The expectations regarding operational leaders spending time on the shop floor are not set. Interactions on HSER are generally one way and focus on compliance rather than improvement.	HSER investigations, risk assessments, and SSWOW reviews are carried out by the HSER Manager.	A leader on site is not able to explain the key disciplines under LIA. Safety improvement every day through the Safety Cross at the DAC. Every meeting starts with a safety share. The site has one Take 5 Safety interactions. Critical Control Monitoring Plans, SPI injury investigation protocol, Working Men's	There is a Daily Action Centre, but it is not a holistic meeting and contains some but not all of the following subject areas: HSER, Quality, Customer Service, Operations, Maintenance.	All subject leaders and the Site GM do not attend the Daily action centre as a routine. The meeting starts and finishes on time. The meeting is led by the same individuals each day.	No expectations are defined.	No formal training or coaching is place.	Less than 50% of employees performed Take 5.	Managers and front line supervisors have not received formal training.

In order to help drive organisations towards implementation of Leadership in Action, a roadmap can be developed specific to your organisation set expectations and measure progress.

Roadmaps are very effective when linked to clear strategy and appropriate training and coaching to support leaders implement the necessary actions.

# Promoting the Engagement

