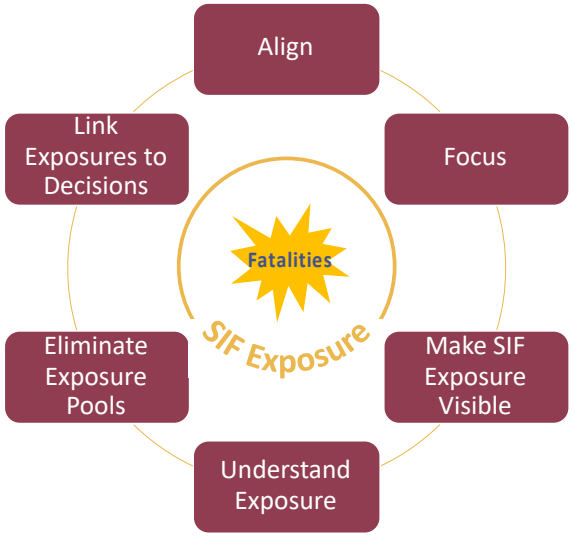
SAFETY LEADERSHIP TO PREVENT SERIOUS INJURIES AND FATALITIES

SÄKU Säkerhets Kultur Nätverket

KRAUSE BELL GROUP



2 April 2025

Craig Henderson – GSK – Global EHS Director

Filip Coumans – Krause Bell Group – MD EMEA

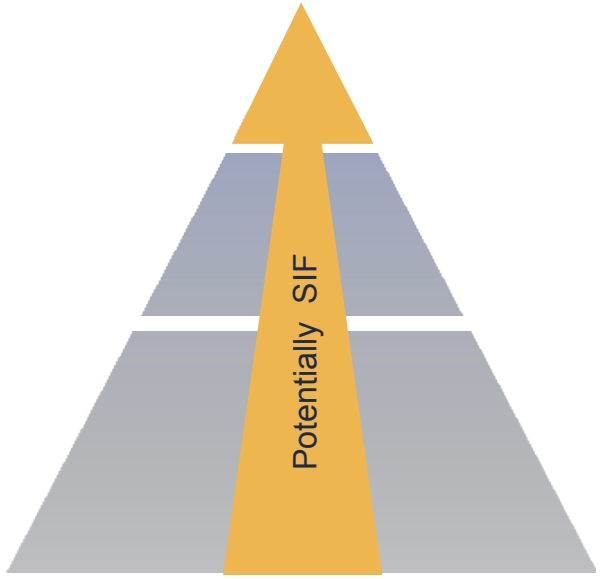
KRAUSE BELL GROUP IS DEDICATED TO THE PREVENTION OF SERIOUS INCIDENTS AND FATALITIES BY IMPROVING HOW YOUR ORGANISATION FUNCTIONS.

Our research-based interventions strengthen decision-making and leadership, address behaviour and build culture to create safe, healthy, and high-performing organisations.

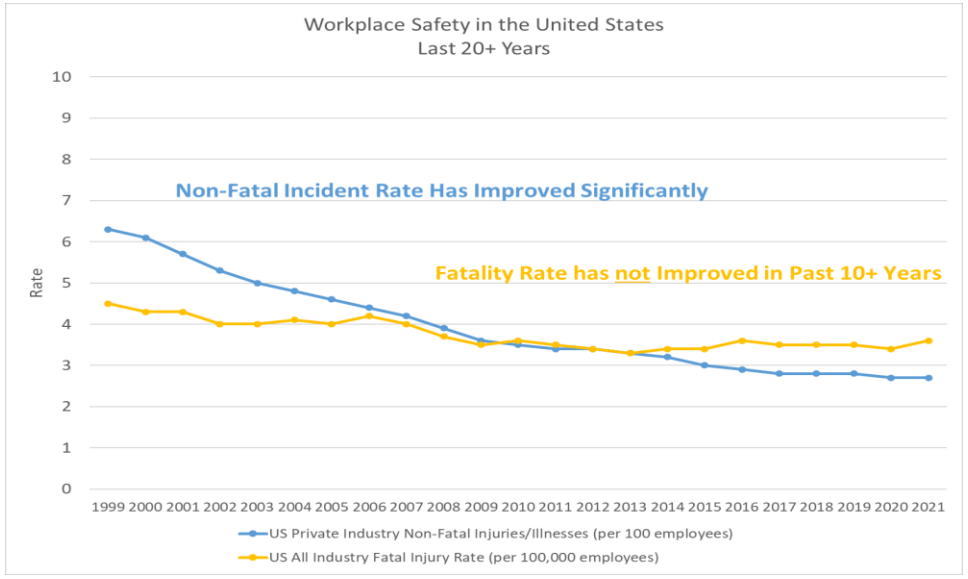
- Safety Improvement Strategy Development
- SIF Reduction Mechanism
- Culture Assessment & Survey
- Leadership for SIF Prevention 360 Rater Tool
- Executive Safety Leadership Mentoring
- Enhancing Safe Decision Making® Effectiveness
- Safe Decision Making® Simulation
- Employee Engagement Methods.

WHY FOCUS ON SERIOUS INCIDENTS AND FATALITIES?

2010 Study led by dr. Thomas Krause



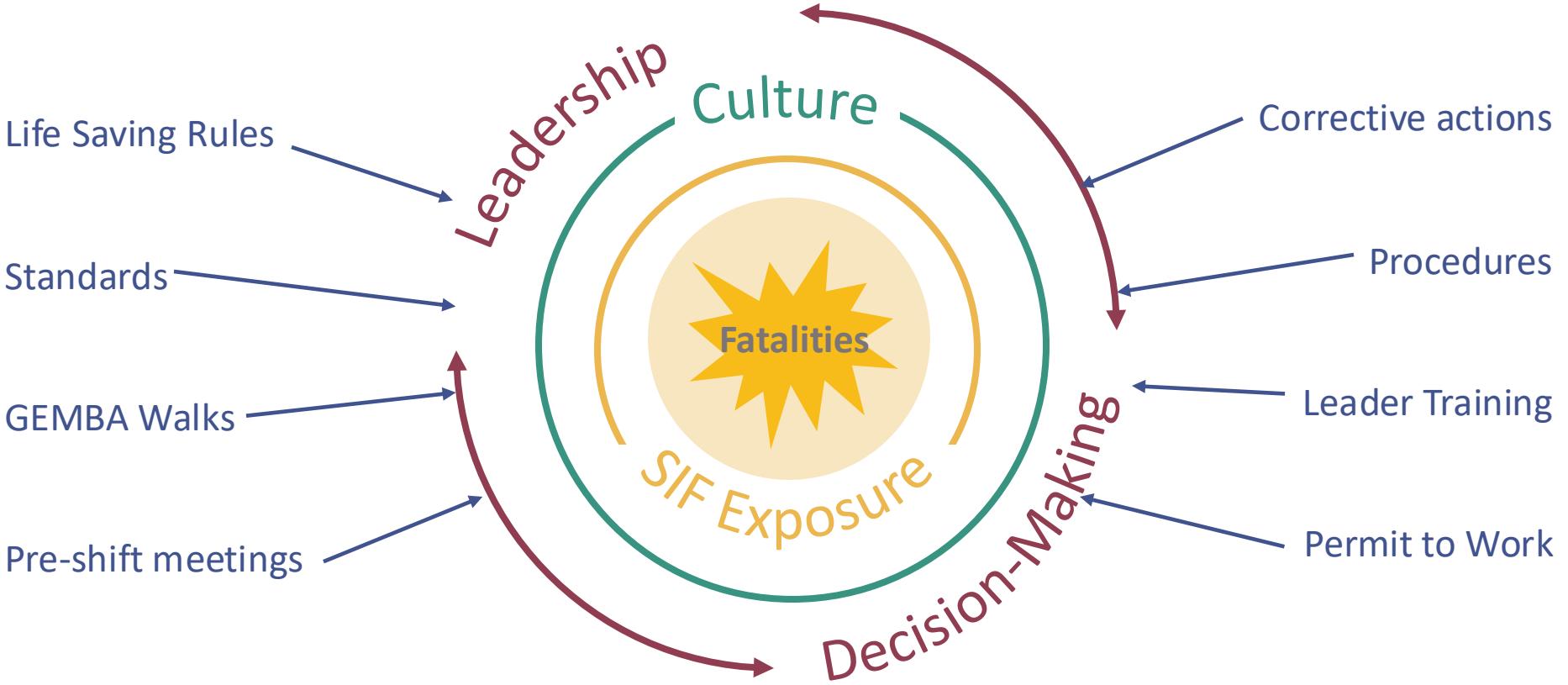
Injury and fatality statistics till 2021



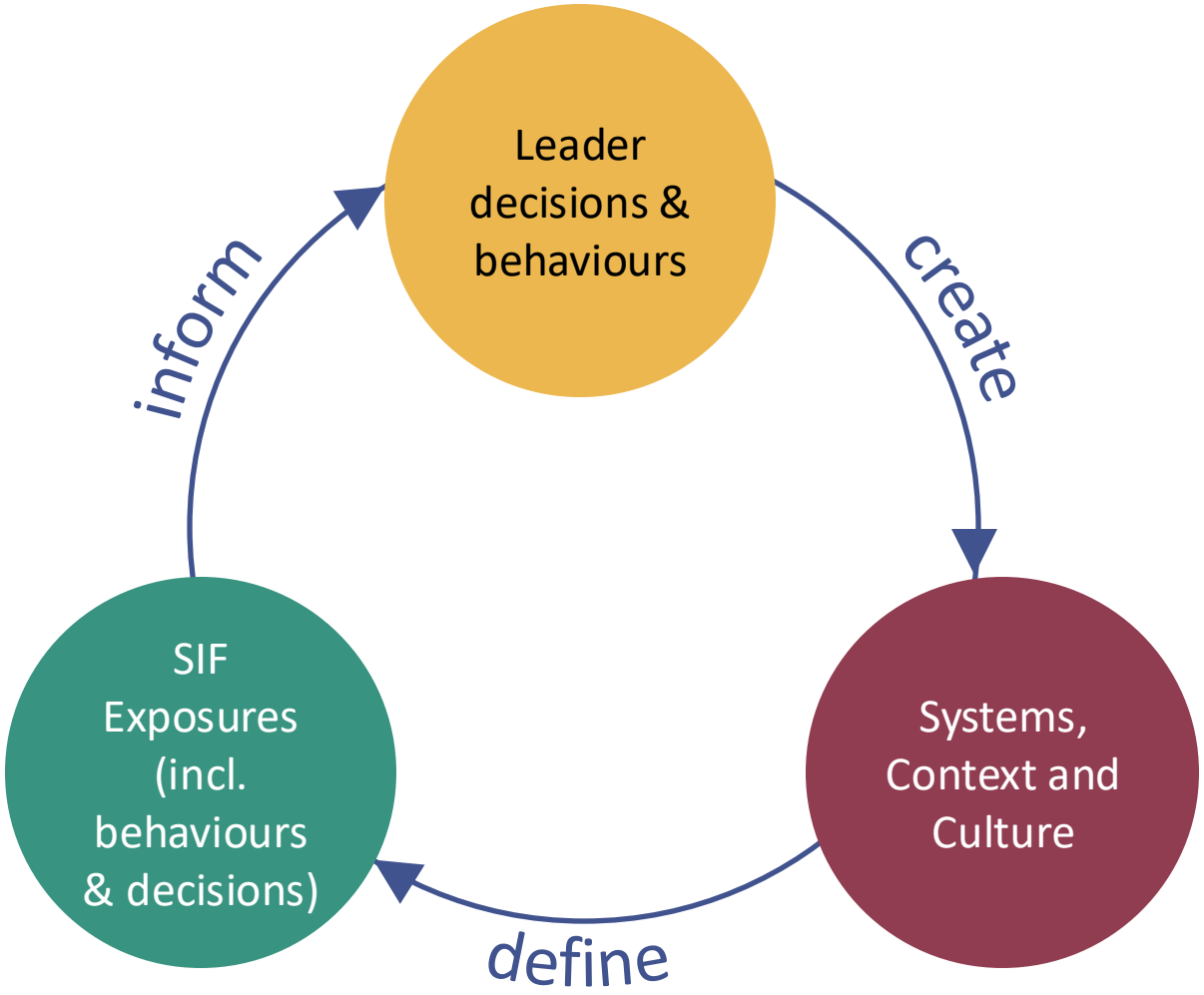
EFFORTS TO PREVENT FATALITIES ARE EFFECTIVE TO THE EXTENT THEY UNCOVER AND ELIMINATE SIF EXPOSURE

TWO MOST COMMON BARRIERS TO IMPROVEMENT:

1. CULTURE
2. LEADERSHIP & DECISION MAKING



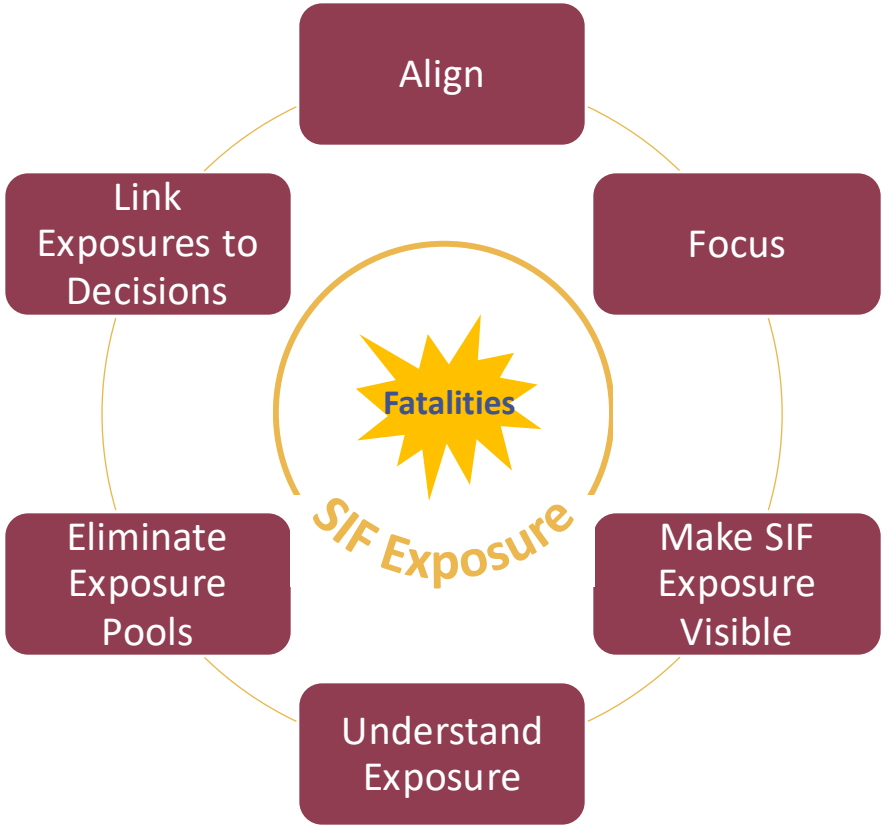
THE FEEDBACK LOOP ON SIF EXPOSURES IS BROKEN

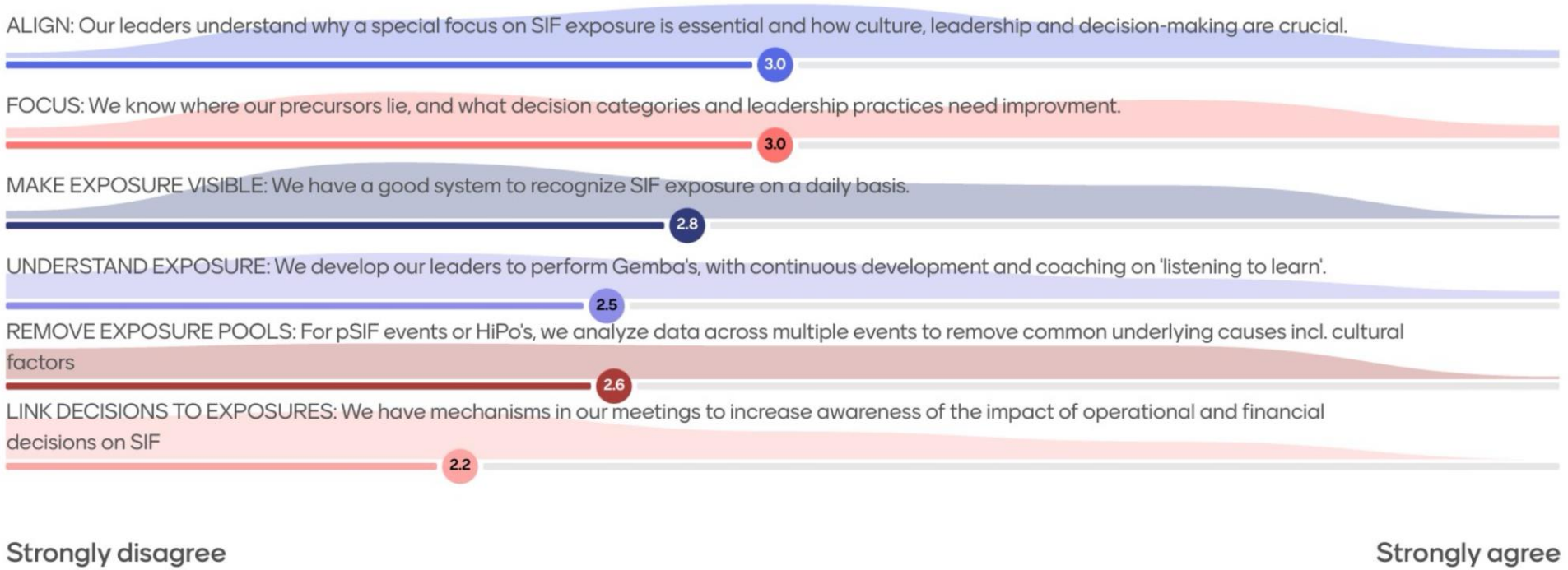


1. Leaders don't fully understand how their leadership behaviours and decisions impact not only systems, but also context and culture.
2. We fail to understand how those systems, context and culture inform the behaviours that employees make, and
3. Leaders receive insufficient feedback on the SIF exposures and surrounding systems and culture to inform their decisions.

THE SIF REDUCTION MECHANISM

6 THINGS YOU MUST WORK ON





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KRAUSE BELL GROUP
Data-Driven Innovation

A global biopharma company who research, develop, manufacture and supply products that result in better health outcomes, for millions of people.

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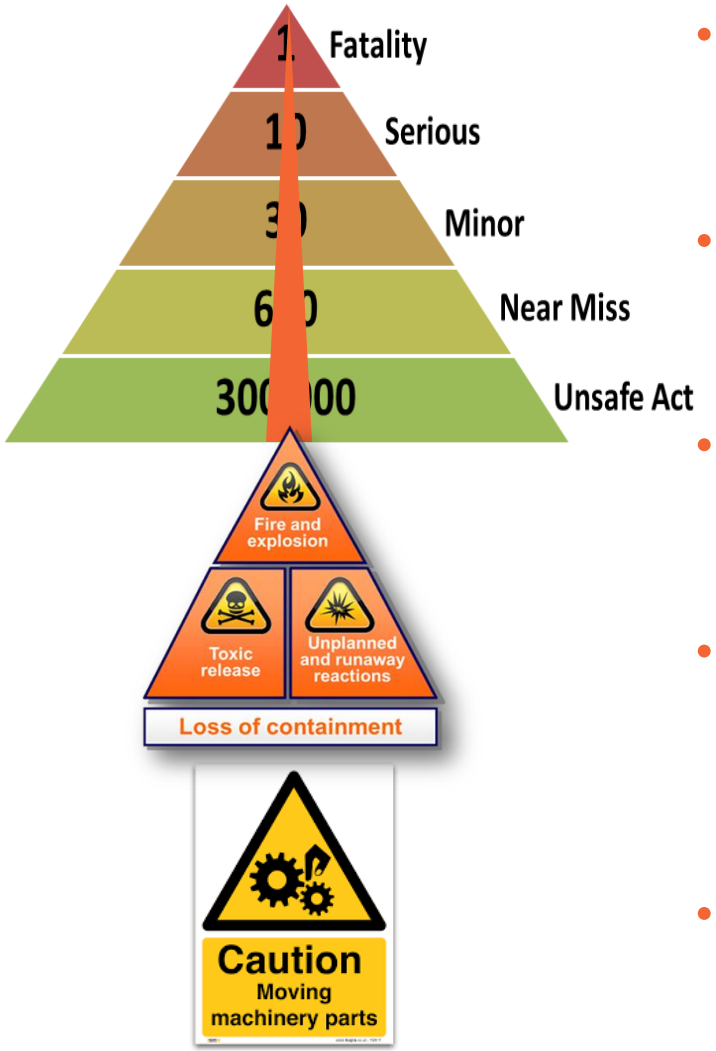
Our Safety starting position

- Fatalities across the company = unlikely (5-10years)
- Lost Time Injury Rate = ~0.30
- So, we were good.
- We had had multi year focus on Process Safety and Machinery Safety
- Always pushed from a Safety technical perspective. Touching on leadership for the few.
- Parts of the organisation were reasonably mature in behavioural safety. Initiative over previous 13 years

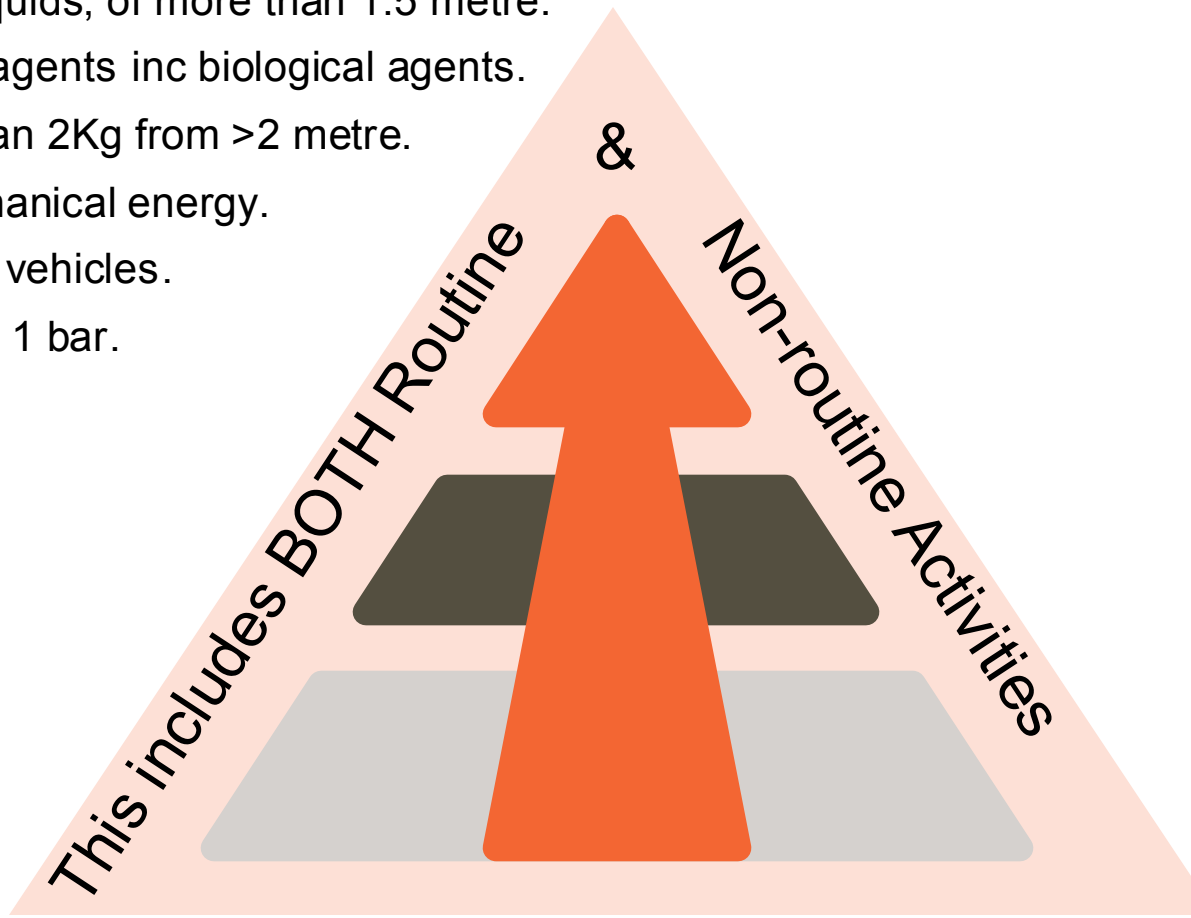


- Divisional differences in Safety maturity
- 2 SIF events at the same facility within 5 years.
- Senior leader with previous experience of Krause Bell Group.
- Performed a diagnostics by interacting with ~250 employees – cross sectional group.
- Programme developed to address opportunities.

Created a list of our SIF Activities (the full triangle within the triangle)

Activities that have the potential to result in a serious injury or a fatality

- Working at Height including around holes in the ground & deep liquids, of more than 1.5 metre.
- Working with a process with potential for exposure to hazardous agents inc biological agents.
- Working in the vicinity of a potential falling item weighing more than 2Kg from >2 metre.
- Working with or around dangerous moving parts and stored mechanical energy.
- Working around mobile equipment and other workplace transport vehicles.
- Working on or around a system containing pressurised material > 1 bar.
- Working on or around a system that contains flammable material.
- Working on or around asphyxiant gas hazards.
- Working on process safety protective devices.
- Working with or around hazardous chemicals.
- Working in or around extreme temperatures.
- Working with electricity (>50v).
- Working in a confined space.
- Working with lifting systems.



(SIF Activities = high hazard)

Gravity / Lifting / Working at Height
(including Holes & Deep Liquids)

- Escalate within 24 hours.
- Full Investigation started immediately.
- Log details onto EHS One.
- Prepare a one page briefing (e.g., Flash Report).

SIF

- A fall from > 1.5 metre (from height or into a hole from ground) that resulted in a fatality or a permanent disability or the need for immediate life-preserving rescue actions.
- Incidents involving lifting items or items falling that resulted in a fatality, permanent disability or the need for immediate life-preserving rescue actions.

- Escalate within 48 hours.
- Full Investigation started immediately.
- Log event into EHS One.
- Prepare a one page briefing (e.g., Flash report) once investigation understood.

Potential SIF

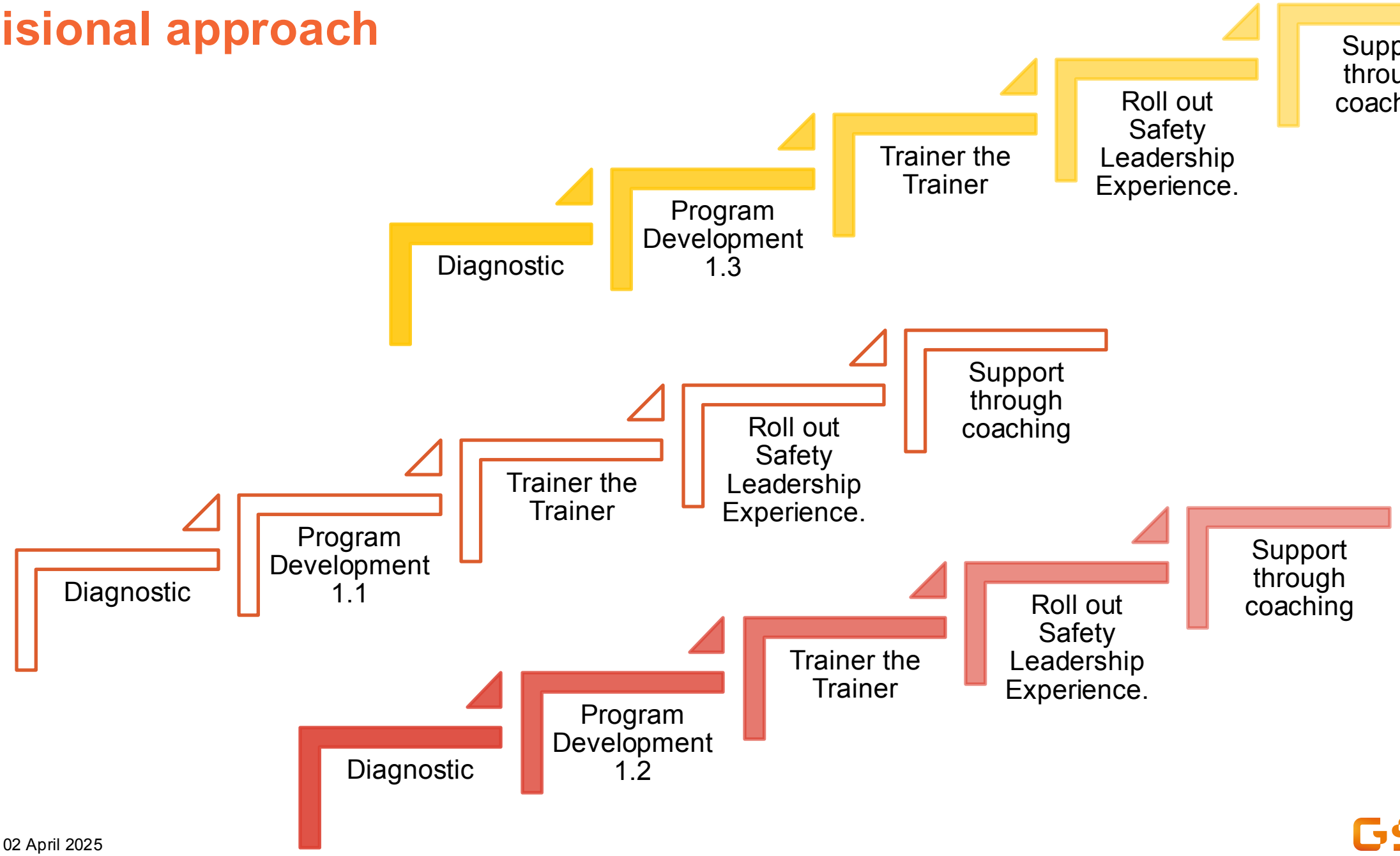
- Incident or near miss whilst working at height > 1.5 metre or involving lifting items or items falling that could have resulted in a fatality, permanent disability or the need for immediate life-preserving rescue actions.
- Any injury that had the potential to be a fatality, permanent disability or the need for immediate life-preserving rescue actions.
- Specifically:
  - A fall from > 1.5 metre from height or into a hole or excavation.
  - Failure of Scaffold or working platform, including temporary flooring or ladder / steps.
  - Activation of Fall Protection or failure of protective barriers.
  - A failure of a physical control, such as a physical barrier found faulty or not approved or bypassed or a Harness found inadequate.
  - Collapse of a trench or supporting walls in excavations.
  - The failure of any part of a lifting equipment, including deformation.
  - The collision during lifting with any other piece of equipment.
  - Any alarm or safety activation from a Crane or lifting device.
  - The fall of any item greater then 2KG from a height greater than 2m.
  - Failure to keep the lifting zone / exclusion zone clear.
  - Unauthorised deviation from the GSK agreed Lifting plan / Method Statement resulting in a serious incident or near-miss.

- Manage locally.
- Complete simplified Investigation.
- Keep high level details for annual reporting.

ZAP / Near Miss

- Anything not called out specifically above unless extenuating circumstances.
- Anything that is called out above but deemed to not be a Potential SIF by Regional EHS Lead due to the confirmed presence of other reliable controls protecting from the hazard.

Divisional approach



SIF Management System

- ↓ SIF events
- ↓ Reactive pSIF events
- ↑ Proactive pSIF events
- ↑ Discretionary energy
- ↑ Trust
- ↑ Safety conversations
- ↑ Life Saving Rules in use
- ↑ Leader focus on system improvement.
- ↑ Leaders Safety Accountability

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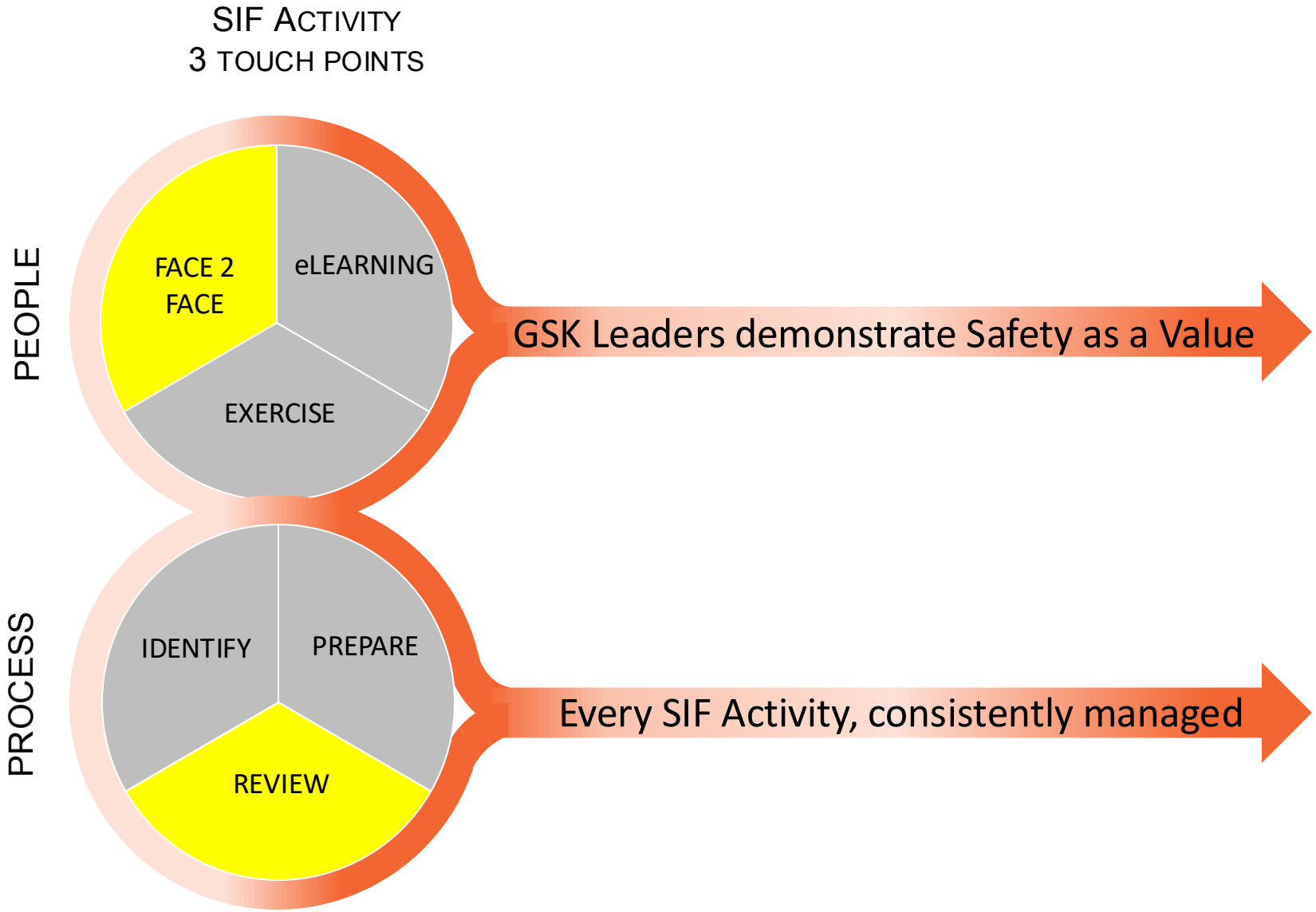
SIF Management System

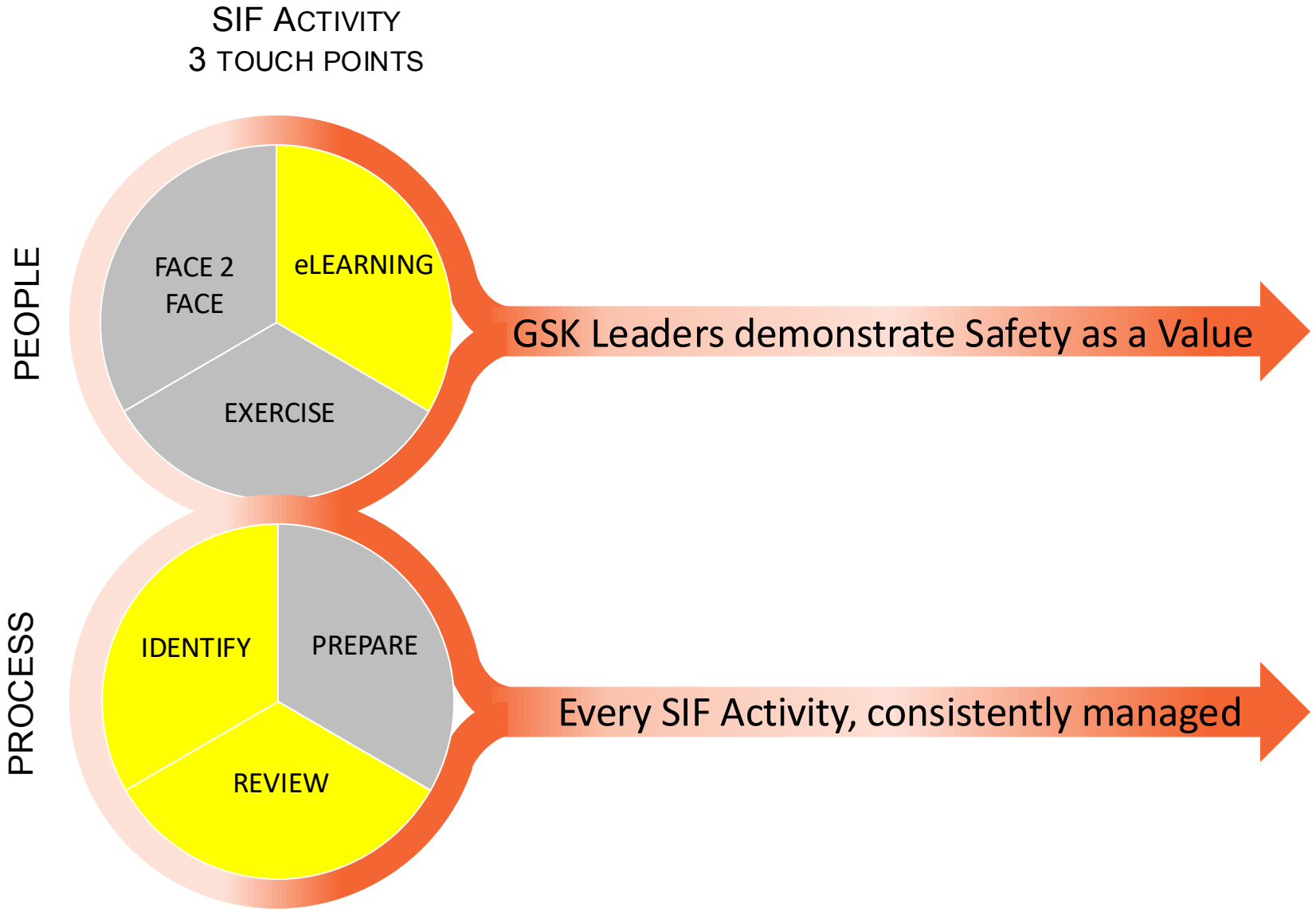


Year 1 & 2

- Focus on the face to face delivery of the Safety Leadership Experience.
  - 3 x Half day (4 hour) sessions
  - 8 x 60 min coaching
  - >6000 Leaders participated.

- Set the expectation of Leaders to visit the workplace and engage in a meaningful safety conversation. Especially around SIF Activities.
  - Measure and track performance

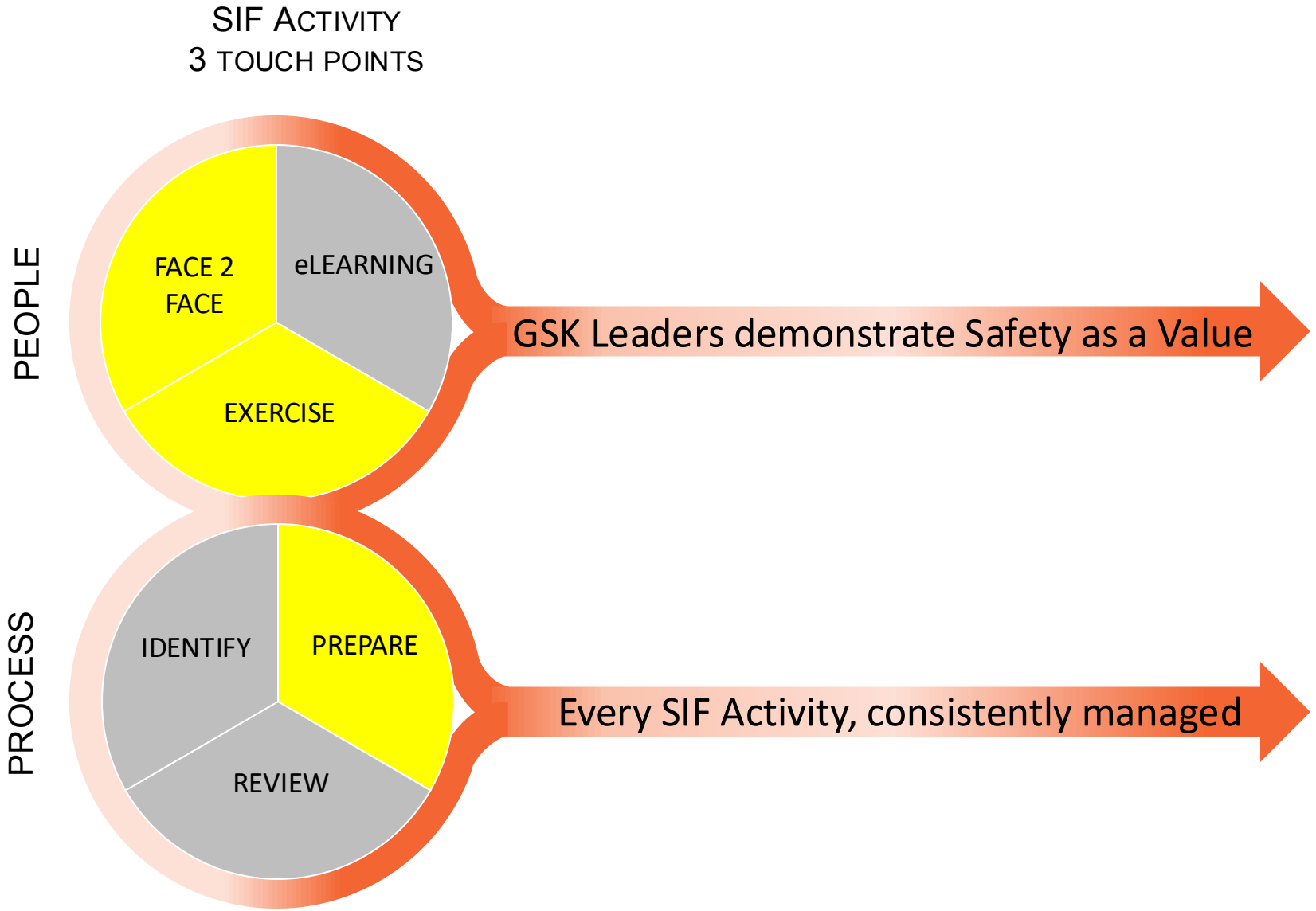
SIF Management System



Year 2 & 3

- Created 3 x 30min eLearning animations to reinforce the key steps of SLE.
- Identify the SIF Activities carried out across each of our facilities.
- Maintain the expectation of Leaders visiting the workplace and engaging in a meaningful safety conversation. Especially around SIF Activities.
  - Measure and track performance

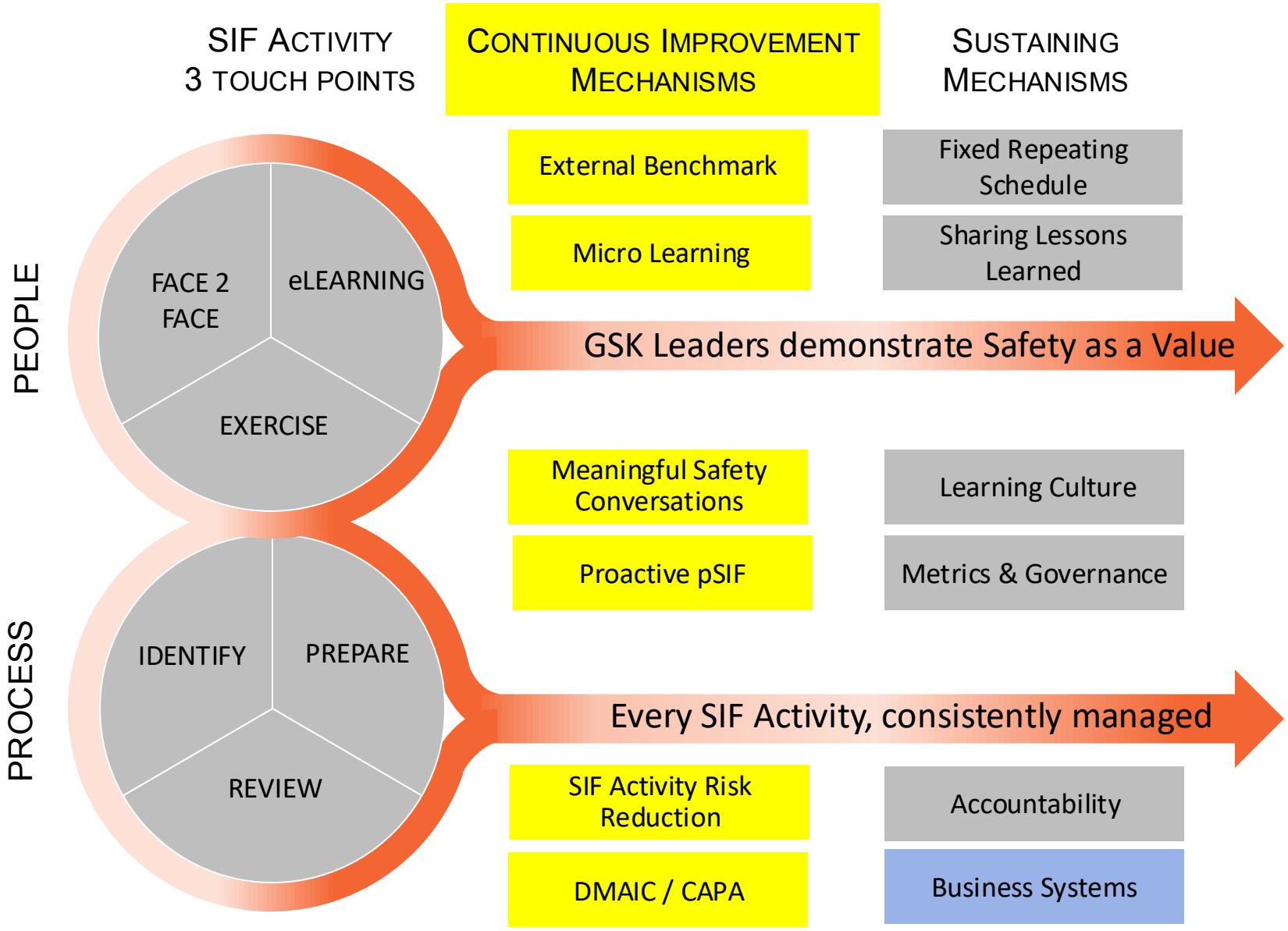
SIF Management System



Year 4

- Focus on the face to face delivery of the Safety Leadership Experience – SIF Management.
  - 2 hour face to face
- Team Exercises to reinforce the key steps of SLE.
- Leaders will have face to face discussion BEFORE the SIF work begins. Move from Fast to Slow brain thinking.

SIF Management System

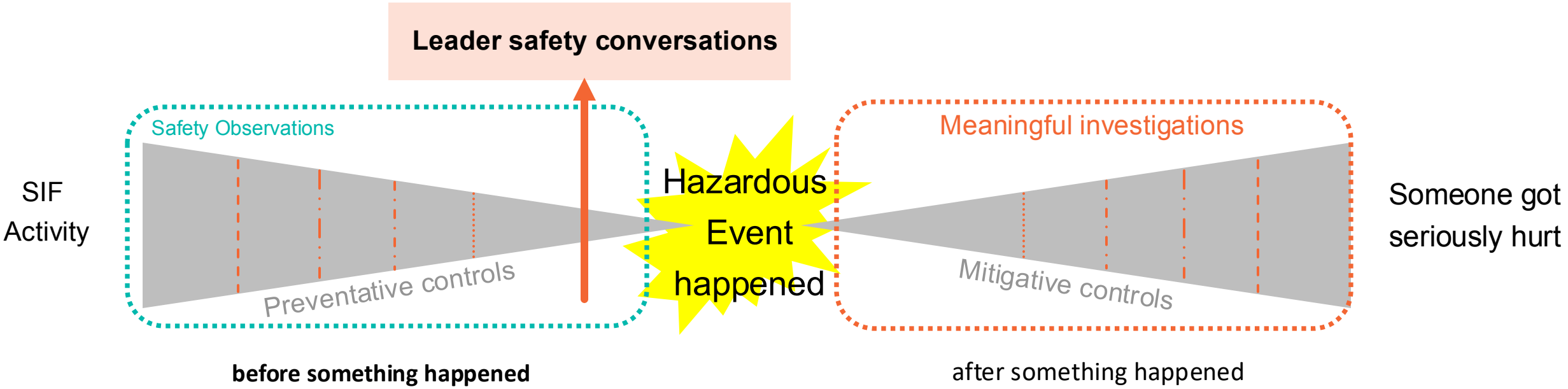


Ensure we have clear Continuous improvement mechanism built into the programme.

Linking the Meaningful Safety Conversations to the proactive pSIF reporting.

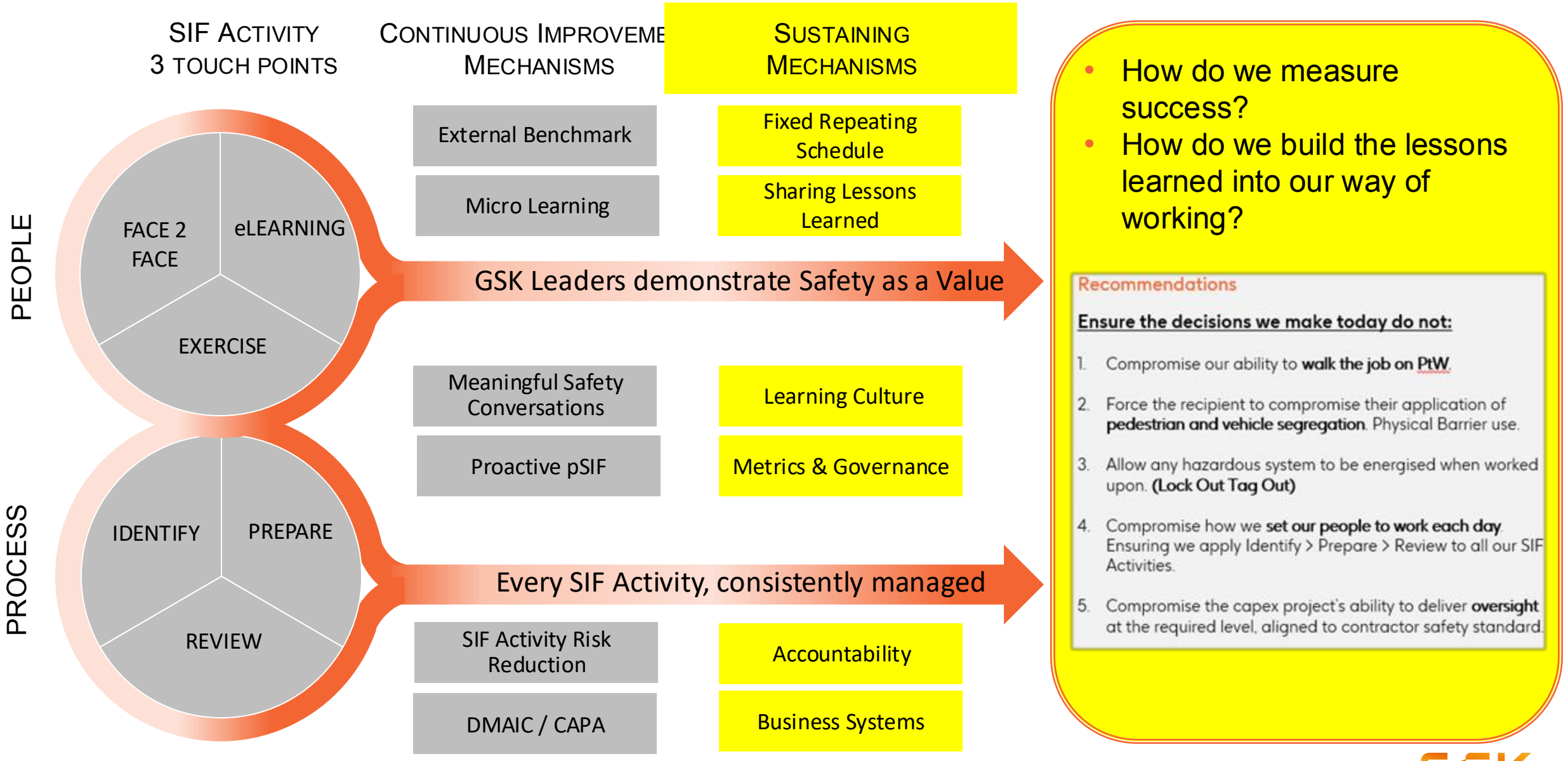
Training people on how to have a Meaningful Safety Conversation, providing supporting material and coaching then include it in the daily process.

Continuous Improvement mechanism…



- Historically we had only used data from our meaningful investigations of reactive events (after something has happened)
- This means we have relied on mitigative controls and or luck to keep our people safe.
- We collect data on observations and maybe fix the immediate issue/s, but no significant learnings are obtained.
- Linking our Leaders safety conversation in the workplace with a focus on identifying and investigating before anything has happened allows us to improve without exposing our people.
- By expanding slightly into the proactive area we can improve our systems thus preventing a future reactive pSIF or SIF.

SIF Management System



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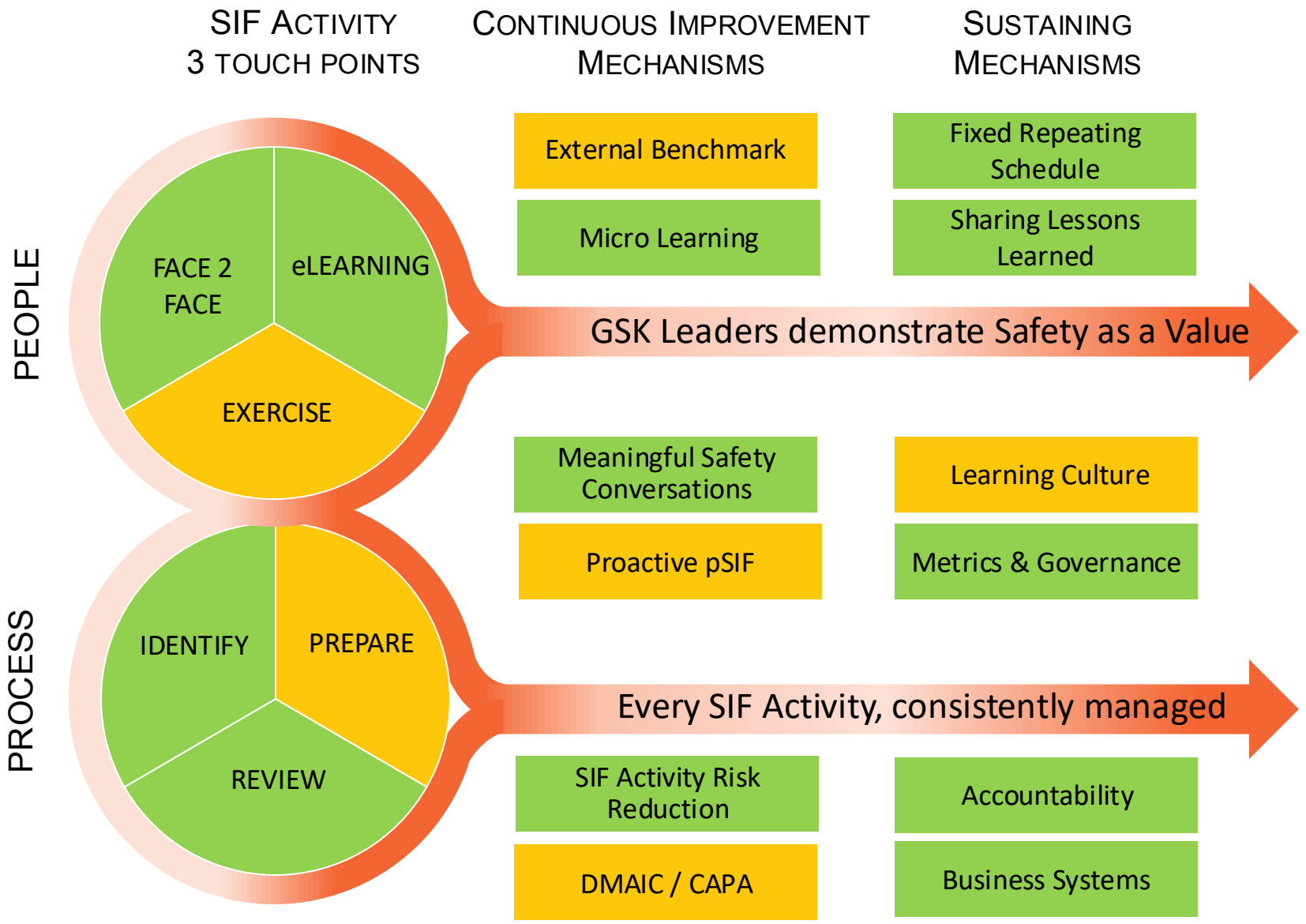

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Questions?

INTERESTED IN THIS SIF PREVENTION? JOIN THE SÄKU CONFERENCE ON 16-7 SEPTEMBER

End of Presentation

Thank You!