

Safety Is Not a Program. It Is How an Organization Operates.

Why shared responsibility, leadership accountability and Gemba matter more than another safety initiative

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The difference between managing safety and leading it

During a previous executive leadership engagement, I worked with an industrial manufacturer seeking to strengthen safety across a complex operating environment. The organization had established procedures, safety professionals and injury reporting. The deeper question was whether safety was being managed as a function—or led as an integral part of how the business operated.

Managing safety can become an exercise in compliance, reporting and responding after an incident. Leading safety requires a system that connects intent, work design, frontline engagement, accountability and continuous improvement.

Safety is everyone's responsibility. Leadership is accountable for making the system work.

Freedom within a framework

Different facilities face different hazards, equipment, work practices and capability levels. A uniform checklist alone cannot solve those differences. The answer is a common management framework—clear standards, decision rights, measures and escalation—combined with local ownership of practical improvements. The goal is not a larger safety bureaucracy. It is stronger operating capability.

Everyone participates; leaders remain accountable

Employees must be able to recognize hazards, follow safe practices, report near misses and improve their work. Supervisors reinforce safe execution and remove immediate obstacles. Plant and operations leaders own the effectiveness of controls, resources and corrective action. Executives establish expectations, review leading indicators and intervene when the system is not performing. EHS professionals provide expertise, standards, coaching and independent challenge; they do not replace operating ownership.

The essential management question is not simply “Who is responsible for safety?” It is “How does every person contribute—and how do leaders know the system is working?”

Gemba: leadership goes to where work happens

Gemba—going to the actual place where work occurs—bridges the distance between a leadership report and the reality of production. Injury statistics show what has happened. A disciplined safety walk can reveal what might happen next: awkward reaches, incomplete guarding, rushed changeovers, weak maintenance controls or workarounds that have become normal.

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The purpose is not to catch someone making a mistake. It is to observe, ask, listen and understand the conditions that shape behavior. Effective walks end with clear action ownership and a return visit to verify that the hazard has actually been controlled.

Observe the work → Engage employees → Identify risk → Correct the system → Verify effectiveness.

A management system, not a collection of programs

The approach drew on connected disciplines: a shared safety vision, leadership and employee engagement, safety committees, communication, training, audits and hazard identification, risk prevention, incident investigation, performance measurement and compliance. Each element matters; the connection between them matters more.

One way to operationalize those disciplines is a 20-point safety management framework: twenty governed expectations supported by process- and job-level playbooks. The framework establishes the enterprise standard; the playbooks translate it into decisions, handoffs, controls, qualifications and evidence. A plant may adapt its work methods to local risks and regulation without relaxing the underlying standard.

For the practical architecture behind this approach—including the distinction between process and job playbooks and the idea of making the person doing the work the hero—see the companion Compass Insights article, “From Strategy to Execution: Why Frameworks and Playbooks Matter.” The twenty-point model is illustrative, not a reproduction of a former employer’s proprietary system.

Cross-functional root-cause reviews bring operators, engineering, operations, quality, HR and safety expertise together. Near-miss reporting surfaces weak signals before injury. Standardized playbooks clarify expectations, while model facilities demonstrate practical methods that other teams can adapt. Integrating safety with 6S, standard work and continuous improvement makes it part of production management rather than an activity alongside it.

Safety is designed into the entire value stream

The safety of a production employee is shaped by decisions made long before the shift begins. Purchasing determines incoming material and equipment requirements; receiving manages docks, loads and unloading; logistics determines storage, forklift routes and pedestrian separation; engineering establishes flow, ergonomics and safeguarding; maintenance controls equipment integrity and hazardous energy; and packaging and shipping manage lifting, pallet stability and outbound loading. Each function owns the risks it can influence. Operations leadership remains accountable for the performance of the integrated system.

Consider a modernization project. A capital request may promise higher throughput, but its safety case should also address machine guarding, robotic-cell access, interlocks, lockout/tagout (LOTO), maintenance access, material presentation, ergonomics and emergency response. A formal management-of-change (MOC) review should occur before purchase, during commissioning and before release to production. Automation can eliminate exposure to hazardous work—but can also introduce new risks if design and implementation are disconnected.

The same discipline applies to receiving and shipping: a near miss at a loading dock, a damaged pallet, or repeated manual handling is not merely a local issue. It is a signal about supplier specifications, material flow, layout, packaging design or standard work. Gemba gives leaders a way to see those connections and assign corrective action to the right process owner.

What improved—and what the evidence means

In a regional North American manufacturing operation employing approximately 3,500 people, a comparison of equivalent five-month reporting periods showed substantial improvements in reported safety outcomes. The figures illustrate the scale of improvement that can be tracked when safety is managed as an operating discipline; they do not establish that any single practice caused the change.

Regional, period-matched observations; not global results or evidence that any single practice caused the change.

Performance measure	Earlier period	Later period	Improvement
Medical-treatment injuries (MTIs)	133	87	35% reduction
Lost-time accidents (LTAs)	42	27	36% reduction
Workers' compensation claims	97	79	19% reduction
Workers' compensation reserves	\$1.00M	\$443K	56% reduction

A common safety language across borders

International implementation required more than translating a playbook. Leaders needed common definitions, a consistent reporting cadence, and comparable measures—while respecting local legal requirements, languages, workforce practices, and regulatory reporting rules. A lost-time accident (LTA), medical-treatment injury (MTI), near miss, and corrective action had to mean the same thing in management reviews, even when statutory reporting differed by country.

The scorecard combined lagging measures—LTAs, MTIs, workers' compensation claims and reserves—with leading measures such as near-miss reporting, safety observations, Gemba participation, hazard-assessment completion, overdue corrective actions, training, and verification that controls actually worked. Where exposure hours were reliable, frequency rates could normalize injury counts so a small plant and a large plant were not compared solely on raw totals.

We also needed discipline around data quality: a common reporting period, agreed definitions, ownership of each metric, timely incident entry, and clear escalation when a serious exposure was identified. More reported near misses could initially signal stronger employee trust and hazard visibility—not necessarily worsening safety. Leaders had to interpret the measures together and go to Gemba to understand the story behind the numbers.

The practical international scorecard distinguished outcomes from prevention. LTAs and MTIs described harm already experienced; near misses, hazard observations, machine-guarding assessments, root-cause analysis (RCA), corrective-action closure and Gemba reviews showed whether prevention was functioning. A common incident tracker, defined reporting windows and divisional action owners made the information actionable. One documented operating practice required incidents to be entered within two working days; another called for safety to appear on platform leadership agendas at least quarterly.

The Compass Operating Model: five disciplines

FOUNDATION™ Establish values, trust, clear expectations and the accountability structure that allows employees to speak up and leaders to act.

SIMPLIFY™ Design hazards and unnecessary complexity out of work; make the safe method the most reliable method.

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LEAD™ Make leadership commitment observable through Gemba, coaching, resources, decisions and follow-through.

GROW™ Develop the ability of every employee, supervisor and leader to recognize risk, solve problems and share learning.

ARC™ Analyze performance and emerging risks, Refine controls and work practices, and Commit to verified corrective action.

A cadence that keeps prevention alive

Daily huddles surface immediate hazards. Weekly reviews close actions and remove barriers. Monthly operating reviews examine trends, repeat exposures and capability gaps. Quarterly leadership reviews test whether the overall system is improving. The objective is not more meetings; it is timely decisions supported by evidence from the workplace.

The broader leadership lesson

Safety is a particularly visible test of an organization's operating model, but the same principles apply to quality, talent, customer experience and productivity. Strategic intent must connect to work design, clear accountability, capability, execution evidence and a continuous learning loop. Without that connection, programs multiply while performance remains inconsistent.

Build the foundation. Simplify the work. Lead through behavior. Grow capability. Analyze, refine and commit.

A strong safety culture is not proven by a slogan on the wall. It is demonstrated when people identify risk, leaders act before harm occurs, and the organization learns faster than problems recur. Safety is not simply a program we manage. It is a reflection of how we operate—and how we lead.

ABOUT THE AUTHOR

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