POSTSCRIPT

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Seeing risk before it strikes

Reflections from the Operational Risk Management Community of Leaders, Inaugural roundtable, IET Savoy Place, London, 2 July 2026

On 2 July, senior operational risk, safety and resilience leaders from across HSE, Risk, Operations, HR, ESG and Regulatory functions came together in London for the first session of the **Operational Risk Management Community of Leaders**.

Three patterns ran through the day: the exposure organisations worry about most is usually already sitting in data they hold; the incentives and governance structures in place often work against surfacing it; and Boards are rarely equipped to ask the right questions of what does reach them.

What followed wasn't a presentation. It was a mirror, and the room spent the rest of the day working out what to do about what it saw.

When polled* at the outset, the room made that instinct concrete: asked which risk their board was least prepared for today, 75% of leaders chose governance failure — the questions we never pursued — ahead of reputational collapse (17%), personal liability (8%), or even the human cost of people harmed under their watch (0%). The gap, in other words, was not in awareness of what can go wrong, but in whether the right questions are being asked before it does.

*The poll drew twelve responses from the senior leaders present.

The uncomfortable questions of the day

The questions put to the room by dss+ UK Director Paul McNeillis hosting the event were twofold: firstly, with budgets tightening everywhere, how do you make a powerful business case for investing in truly pro-active operational risk management, particularly when judging by lagging indicators "nothing appears to be going wrong"? Secondly when you do have the attention of the Executive and the Board how do you master evidence and insight to communicate with them in a way that enables them to make well informed decisions such as which risk mitigation measures to prioritise and what investments to make. "In times like these risk professionals need help in sharpening their case" McNeillis explained drawing on dss+ interactions with its UK clients and wider risk networks in the last 12 months.

Drawing the line between cost and risk

A client challenge was presented

An incoming Chairman at an oil and gas operator, concerned about safety and plant availability, commissioned an independent review of a business built on late-life assets. It found equipment in poor condition and a mindset of "normalisation of deviation," rooted in how budgets were built: department requests routinely met an arbitrary "management override," a cut of 20%, say, driven by financial constraints rather than risk. Over time, that bred what Don Lloyd, dss+'s Managing Director, Risk Management, called a mindset of "learned helplessness". When the cuts reached the Board, the question was direct: how and where do you draw the line between cost and risk? The answer was that the Board had visibility on cost and none on risk, so it defaulted to cutting maintenance and reacting only once something broke.

dss+ approach and solution

The solution started with a shift to risk-based budgeting: every proposal now had to show not just the cost of the work, but the risk and the benefit of not doing it.

Impact

Budget conversations became more structured, more transparent and far less emotive. Communication improved, and so did safety performance, plant availability and morale, because every pound spent, or not spent, now had a clear, risk-based reason behind it.

Not a one-off

Don Lloyd's takeaway: a Board that can't see risk will always default to cutting cost. It isn't unique to this operator either. A related dss+ perspective on Board oversight of operational risk flags the same warning signs across industries, injury rates trending down while serious incidents persist, unplanned shutdowns occurring and rapid cost cuts not founded in risk based decision making.

> "Boards don't know what they don't know."
>
> **Don Lloyd, Managing Director, Risk Management, dss+**

What the data already knew

If Don Lloyd's case study showed what happens when a Board can see cost but not risk, Nuno Santos's contribution showed why that gap exists in the first place. It opened with the same provocation that had been hanging over the room all day, sharpened into one line: every organisation represented had a certified management system, audited, documented, compliant.

So why do people still get hurt?

> We have a management system, we have data. But we still hurt people."
>
> **Nuno Santos, EMEA/LA Digital & Innovation Lead, dss+**

He backed it with two cases that made the point with uncomfortable clarity.

In the first, across a single operation, more than **one million safety records** had been reviewed over the period. Fewer than **5%** addressed conditions that could cause a fatality. The injury rate stayed green throughout, despite multiple fatalities occurring within the same period. The exposure was never hidden: it was sitting inside data the organisation already held.

In the second, from a site with 70 recorded fire events, the pattern repeated: 43% had been closed without a detailed investigation, and 16 remained open at the time of review. The system was reporting closure rates. It was not reporting learning.

Six silent signals

The same session offered six patterns worth checking against your own organisation, the kind of signal that never trips a threshold, and that's exactly why they matter most:

- **Silence where there should be noise.** Near-miss reports suddenly drop off. It rarely means the site got safer, more often it means people have stopped reporting, out of fatigue, fear, or a sense that nothing gets done with the data anyway.
- **Drift inside the green.** Safety checks are still technically "on time," but each cycle they get done a little later than the last. No rule is broken, yet the standard is quietly slipping.
- **The same finding closed twice.** An issue gets marked resolved, then resurfaces at the same site later. A high closure rate looks good on a dashboard; it doesn't mean the organisation actually learned anything.
- **Themes that never break the surface.** The same warning language shows up repeatedly in incident write-ups, but never adds up to a formal event until, eventually, it does.
- **Contractors sensing risk before employees do**. When contractor near-miss rates start moving differently from employees', it's often the earliest signal that something on site has changed.
- **Leadership's read on culture running ahead of reality**. Leaders often believe culture is stronger than the workforce itself reports it to be; a gap worth closing before it's tested by an incident.

It's also why more than one leader pushed back on dashboards alone. Boards, several participants said, want to know what people are actually saying, not just see it compressed into a percentage; verbatim voice carries something a chart doesn't. That matters more than ever with a younger workforce that is often more comfortable communicating through text and images than speaking up in the room, a signal a dashboard alone will never carry either.

The harder conversations

From there, the discussion moved past theory and into the pain points leaders in the room carry.

1

The risk register nobody owns

One leader in the room described a risk register that had quietly become a compliance artefact rather than a management tool: technically complete, disconnected from the business plan, and given only a sliver of Board time each quarter unless someone deliberately forced the agenda. The problem compounded because governance sat outside the country where the risk lived. UK operations reporting into an overseas parent, in this case, made it harder to get regulatory pressure to land with the people holding the budget.

2

Incentives built for the wrong number

A recurring thread: performance and bonus schemes still reward closure rates and observation counts, so that's what people optimise for, regardless of whether it touches the risks that could cause serious harm. One leader illustrated this with a simple measure from their own operation: shift supervisors were spending just 13% of their time on site with teams, and, in their experience, increasing that figure had an outsized impact on the ground.

3

Confidence that has outpaced assurance

More than one leader flagged a version of the same trap: passing an ISO audit or inheriting a strong track record on lagging indicators through acquisition, creates a false sense that safety is "fine" right up until it isn't. One leader described this tension directly while integrating multiple acquired businesses into a single group with a strong track record on lagging indicators. Another pointed to the same blind spot from a different angle: the biggest gaps in their own picture came from sectors they didn't otherwise work in, a case for looking outside your own industry for benchmarks rather than relying solely on your own audit history.

> Culture is what people tolerate. If leaders walk past an unsafe act, it becomes the new normal."
>
> **— one leader in the room**

4

A culture nobody's the exception to

The room's closing reflection on this topic was pointed: what's needed is accountability, consequence management, and a just culture, a deliberate move back toward stronger performance management while keeping the culture open enough that people still speak up. One version of that, offered by the Community members in the room: a safety culture is only truly ingrained once the receptionist feels able to challenge the C-suite on a poor safety behaviour, and is heard when they do.

Take one of these into your next Board meeting:

- Does our risk register speak the language of the business plan, or only the language of compliance?
- Which of our incentive metrics would look different if we designed them purely around leading indicators?
- When did we last test our safety confidence or maturity against something other than our own audit?

Pick one. Put it on the agenda, not as a rhetorical exercise, but as an actual item with an owner and a follow-up date.

Monday morning: five things to ask for

Taken together, the day's two opening questions point to the same starting point: a budget case is only as strong as the signal behind it, and a signal only matters once it reaches a budget conversation. Don't waste a crisis, but waiting for one isn't a proactive risk management strategy either. A few habits worth building on both fronts at once:

- Tie every budget proposal to the same signals the data already shows, not to a separate risk narrative invented for the Board meeting.
- Give budget holders the same tools to show the risk of not spending as they already must show the cost of spending.

The session closed on a practical note: five commitments a Board can make, each paired with the shift it produces.

And three questions worth asking every quarter, without exception:

1. Which of our biggest risks is closer to happening than it was last quarter, and why?
2. For our top three fatal risks, are the controls we rely on working?
3. What did we learn this quarter that we didn't know the quarter before?

If the honest answer to any of these is "we can't tell from the pack" … the report is the problem, not the data.

Five commitments a Board can make

The ask	What it produces
Own the top three fatal risks personally	The list stops migrating between EHS, Operations and Risk: it becomes a standing Board item
Show up where the risk lives: one site visit per quarter	The frontline sees that bad news reaches the top: the precondition for it being reported at all
Open the budget when exposure rises	Barrier degradation gets fixed in weeks, not after the next incident
Hold the executive to risk movement, not headline numbers	Incentives shift from defending the number to managing the underlying risk
Protect the bad news	Reporting stays honest: the only data feed any of this depends on

Some lines worth keeping in mind

If nothing else from the day sticks, these three:

- The exposure is rarely hidden in data nobody has. It's sitting inside reports already being filed, the gap is in what gets surfaced to the people who can act on it, not in what gets collected.
- Whatever carries incentive weight gets prioritised. Time spent by senior leaders on the activities that carry the top fatal risks, at the front line and listening rather than inspecting, is itself a leading indicator: it can be counted, it can be trended, and it is the precondition for honest reporting of everything else.
- An audit confirms the system exists. It says nothing about whether the system is preventing harm.

One question to sit with

The room left with more questions than answers. For a first gathering, that's the right outcome: this Community exists to keep working through them, not to close them off in one session. One reflection from the room is worth carrying forward as the reason this format works at all: a CEO will often listen to a peer CEO in a way no internal report quite achieves. That's the wager behind this Community, that the conversation between peers does work an internal memo can't.

In the meantime, the provocation from the day is worth sitting with rather than resolving too quickly:

What's the one number your Board sees every quarter that you suspect is telling you less than it appears to?

If the honest answer takes more than a moment to find, the data is rarely the problem; the organisation almost always holds the signal already. The problem is a pack designed to display metrics rather than answer questions, and the fix is to build the report backwards from the three questions, not forwards from the source systems.

Curated by dss+. Driven by its members.

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