NAVAL SAFETY COMMAND
SAFETY AWARENESS DISPATCH
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What Is The SMS and Why Should You Care?

"Safety is not a department, it is a responsibility borne by every Sailor, Marine, and leader."
— M.M. Gilday, Chief of Naval Operations

When most people hear the words "Safety Management System" (SMS), their eyes glaze over and they lose interest (*that happens to us in the SA division too*). Hang with us for a second, because we can boil it down a bit. Have you ever heard the force protection saying, "If you see something, say something"? At the deckplate level (*and dirt level, for Marines and shore-based folks*), that's what SMS means to you.

A SMS is really about managing risks and hazards to avoid harming people (*that's you*) or breaking things. We won't bore you with every detail and element of the SMS, because that bores us in the SA division too, and you can read all that in the instructions. We'll just hit some key points so—along with the "see something, say something" mantra—you'll know what it's getting at. And yes, the Navy and Marines both have an SMS. References for both services' SMS are in the key takeaways.

The SMS has four desired outcomes or "4Ps": Safe Places, People, Property/Materiel and Processes/Procedures—*simple, easy to remember*. To achieve these outcomes, the SMS assigns responsibilities and risk acceptance to the appropriate levels of command from the Chief of Naval Operations to the individual Sailor/Marine/Employee. Why should you care? It's simple. The SMS applies to everything we do, from maintenance to warfighting, and without you doing your part, the system fails and we lose the fight. Not convinced? Here are some mishap examples, including one averted mishap, that relate to each of the 4Ps (*and you*).

Place. A safe workplace or working environment.

A ship was conducting routine operations when the crew received indications of a fire in the No. 1 Gas Turbine Generator (GTG). The crew secured the GTG, confirmed the fire via visual reports and released CO2. Immediately thereafter, a fire alarm sounded for the deck gear locker, two decks above the No. 1 GTG. The fire was located in the uptake trunk near the deck gear locker. The fire was extinguished and no personnel were injured; but the damage caused over 100 lost mission days and over $2 million. The cause: bales of rags stored in the uptake trunk in violation of multiple directives. *—Improper storage in the workplace can lead to devastating damage and loss of warfighting readiness. In this case, the ship had to cancel the remainder of their deployment. Maintain a safe workplace; your life could depend on it.*

People. Service members and civilian employees are trained and qualified on all aspects of their work. This outcome includes working safely, regardless of role, level or position.

An Unmanned Aircraft System (UAS) impacted the ground when the capture hook separated from its wing during recovery. The mishap caused more than $700,000 in damage and the total loss of the aircraft. The cause: Mounting screws were not installed on one of the capture hooks, which were later found on a maintenance table. This misstep was avoidable had a Quality Assurance (QA) inspection been done. However, none of the maintainers were trained or certified to perform the QA. *—We owe it to our teams to provide them with the training and certifications they need to do their jobs.*

Property/Materiel. Proper and available tools, equipment, machinery, infrastructure and whole equipment systems that are safe-to-operate and operating safely.

After numerous pilots in a squadron reported incidents where the aerial refueling store (ARS) baskets did not open correctly, a Sailor in one of the squadrons took it upon himself to figure it out. This motivated Sailor made the rounds on the carrier, visually inspecting all 12 of the ARS basket assemblies aboard the ship, including those belonging to another squadron. He discovered only one on the entire ship was configured correctly. Because of this Sailor's initiative, the air wing was able to repair all the ARS pods and prevent future mishaps. Furthermore, his discoveries opened the door to further investigation and identified additional ARS problems across the Fleet. Well done! —*This good news story of potential mishaps averted demonstrates the importance of being safety minded and to have a questioning attitude. Ensuring you have the right equipment can mean the difference between normal operations and canceled operations. It can also lead to destruction of expensive equipment or loss of lives.*

Processes/Procedures. Established and accessible standard operating procedures, emergency procedures, safety procedures, maintenance standards.

An Amphibious ship was carrying two Landing Craft Utility (LCU) vessels in its well deck. The LCUs were married together in the well deck utilizing a well known, but improper method of lowering the bow ramp of one LCU onto the rhino horn at the stern of the other. The LCUs were shored and griped not following the Wet Well Operations Manual (Wet Well Manual). While underway, the ship experienced 14 ft seas and took a massive roll of roughly 22 degrees to port. This roll created a chain of events that caused the wooden shoring to fall on both sides of the LCUs as the ship continued rolling side to side. The LCUs began shifting back and forth, causing a cascade of gripes breaking catastrophically from the excessive force of the 350-ton LCUs. Three Sailors suffered injuries as the LCUs slammed back and forth in the well deck. The ship returned to port and was removed from participation in its planned exercise. —*Procedures were in place that were supposed to be sound, but Fleet operators made a habit of improvising unpublished processes that became the new normal. If the procedures are lacking, propose changes so they can be checked and updated. As a result of lessons learned from this mishap, the Navy updated it's LCU shoring procedures and training, and changed policy regarding amphibious ship transits in heavy weather.*

SAFETY ASSURANCE AND ASSESSMENTS

One key way NAVSAFECOM is working to ensure you have those safe 4Ps is by their new safety assurance assessments. Don't worry! It is **not** "another inspection to prepare for." The new assurance assessments are there to help your boss, and their boss, and their boss know what you need.

The new assessment process looks at all levels from Echelon II (e.g., Fleet Forces Command) and III (e.g., Naval Surface Force Atlantic) organizations, down to individual units (during Local Area Assessments or LAAs). The assessments aren't focused on a "hit list" at the unit level; they are looking at how the entire chain of command communicates, controls, and manages risk to see how well the whole structure is supporting your unit.

LAAs consist of NAVSAFECOM teams assessing many units in a fleet-concentration area over a week. When the team is at your unit, yes, they will note safety discrepancies they see, but they aren't making a list of gripes to fix. They are looking for trends across many units to help higher commanders, from the Fleet-level on down, know how well they self-assess, self-correct, and communicate gaps and needs up and down their chain. The assessments are NOT about completing a checklist or getting a "to-do" list. They are about making sure you are **safe to operate** and **operating safely**.[1] (*see note on next page*)

And remember, "Let's be careful out there"

*[1]In plain English, **safe to operate** means your place, people, property, and processes/procedures are designed correctly for you to safely do your job. **Operating safely** means executing your mission within the designed safety envelope (usually by following established procedures), controlling exceptions when they happen, and communicating unmitigated risk up the chain ("see something, say something").*

THE NEW PROCESS IS WORKING

In the first several local area assessments, NAVSAFECOM assessors visited multiple units in fleet concentration areas and passed the safety-related trends to the appropriate higher-level commands who could take action. In a number of cases, the reason these issues existed at the unit level is because the commanders with the power to fix them didn't know about them (why "*say something*" is important at all levels of the chain). Here's a sample list (not all-inclusive) of some issues that are now being addressed by higher-level commands now that they know about them from the assessments.

- Facility electrical safety
- Hazardous material storage and handling
- Aircraft hangar fire suppression systems
- Berthing barge habitability
- Personnel and manning issues

Key Takeaways

An effective SMS happens with a culture that self-assesses (looks for chances to "*see something*") and self-corrects; where continuous learning identifies and fixes problems while they're small; where risk ownership and accountability are held at the appropriate level; and hazards and near misses are promptly communicated ("*say something*") up and down the chain of command. Now you have an idea of the desired outcomes and how they each work together to help keep you safe.

1. **Know your role**. From this dispatch, you have a basic understanding of the SMS and your role in it. Your challenge is to live up to that role every day. The culture we speak of occurs when everyone at your unit shares a safety mindset, you included. It goes beyond simply following procedures. It's a shared attitude where all hands operate safely because it is the right and normal thing to do, not just to pass an inspection or complete a checklist.

2. **If you see something, say something.** At the deckplate and dirt level, as you do your job and execute the mission, SMS is about looking for risk, fixing it when you can, and reporting up the chain when you can't (*the same process happens at every level of the chain*). If something doesn't seem safe, tell your supervisor. If you are a supervisor, and you can't fix it, tell your supervisor, etc. Don't assume undue risk to you or your unit by suffering in silence. If you don't speak up, your chain of command won't know about it and can't address the issue. This new SMS is designed to break those barriers, but it takes everyone's commitment to make it work.

For more on the SMS, check out the Who We Are What We Do page on our public website here: navalsafetycommand.navy.mil.

References:
Navy Safety and Occupational Health Manual, OPNAV M-5100 CH-2
Marine Corps Safety Management System, Marine Corps Order 5100.29C

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