PHSC plc

RISK MANAGEMENT CONFERENCE 2026



SEEING THE WHOLE RISK

Tuesday 6th October 2026

La Tour Hotel, Milton Keynes

Today’s programme

Morning	
09:15	Rosie Russell
09:45	Nathan Wilson
10:25	Refreshments and networking
10:50	Professor Tim Marsh
11:25	Richard True: Polypipe case study
11:50	Panel debate
12:30	Lunch and networking

Afternoon	
13:30	Human Factors in Practice
14:45	Refreshment break
15:05	Choice of three sessions
16:25	Conference close

The afternoon: together, then a choice

13:30–14:45	**Everyone returns to this room** Human Factors in Practice
14:45–15:05	**Refreshment break**
15:05–16:25	**Choose one of three smaller sessions** Aquatic Safety / ISO 31000 / Supporting Colleagues in Crisis

15:05: your choice of three sessions

Aquatic Safety	From Management System to Boardroom	Supporting Colleagues in Crisis
Swimming pools and inland water	Using ISO 31000 to strengthen risk decisions	Workplace suicide prevention and readiness
Competence, supervision and safe operation	Connecting assurance with decisions leaders need to make	Expert round table informed by BS 30480:2025

Smaller groups with more opportunity to take part

A few practical points

- Phones
- Delegate pack
- Emergency arrangements
- Questions and help

PHSC Group: three connected divisions

Safety



Consultancy, inspections and occupational hygiene

Specialist support for education, leisure and tourism

PHSC Ltd

IH In House

Inspection Services (UK) Ltd

QLM QUALITY LEISURE MANAGEMENT LTD.

ISO Systems

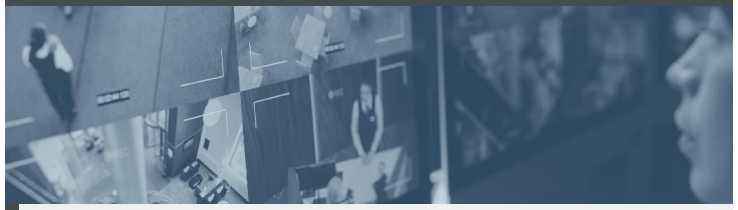


ISO consultancy, auditing and training

Systems that support compliance and improvement

QCS INTERNATIONAL

Security



CCTV, tagging and product protection

Retail loss prevention and footfall insight

B2BSG SOLUTIONS

Training across the Group through PHSC Academy

PHSC ACADEMY

Our heritage and what we bring

Our roots

1990

Personnel Health & Safety Consultants

2005

AIM listed

What makes us different?

Specialist businesses with experience of real operations

Practical advice, with access to wider expertise across PHSC

Why seeing the whole risk matters

The same workplace

Safety, quality, security and wellbeing share the same workplace

One team’s decision can change another team’s risk

The wider picture

The warning signs may sit in different reports

Who else needed to know?

A completed process can still leave a gap

1. A contractor has a permit for intrusive work
2. The drawing is out of date
3. Facilities knows the services have moved
4. **That information has not reached the contractor**

The individual steps can look complete while the overall control is ineffective.

Food for thought through the day

Handover

What could we lose when responsibility passes between teams?

Warning signs

What are repeated workarounds and minor findings telling us?

Shared controls

Which decisions affect controls owned by somebody else?

Work as it happens

Do our procedures reflect how work actually happens?

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RISK MANAGEMENT CONFERENCE 2026



OPENING KEYNOTE:

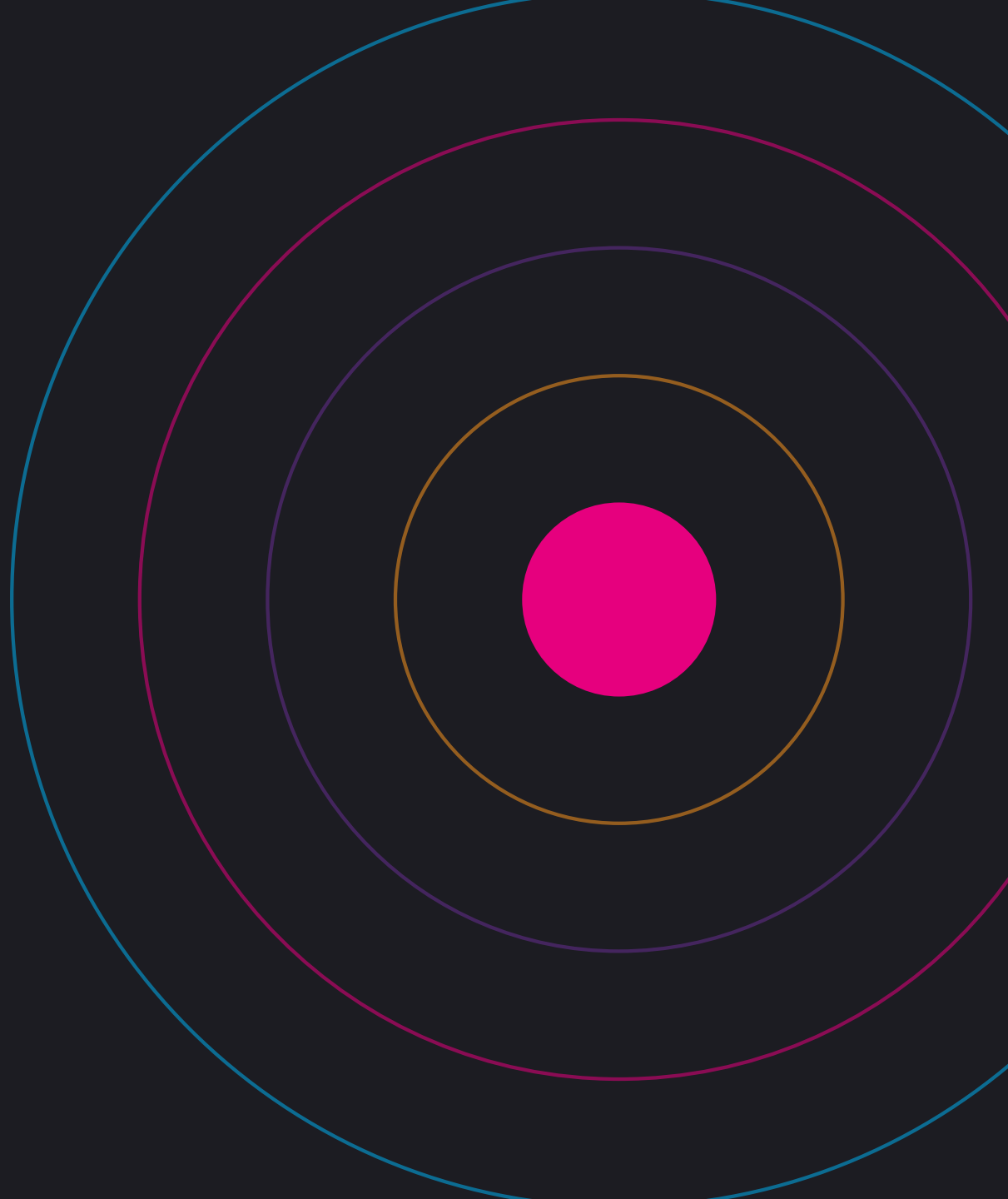
What Organisations Miss When Risks Are Managed In Isolation

Rosie Russell

Co-President, IIRSM · 09:15–09:45

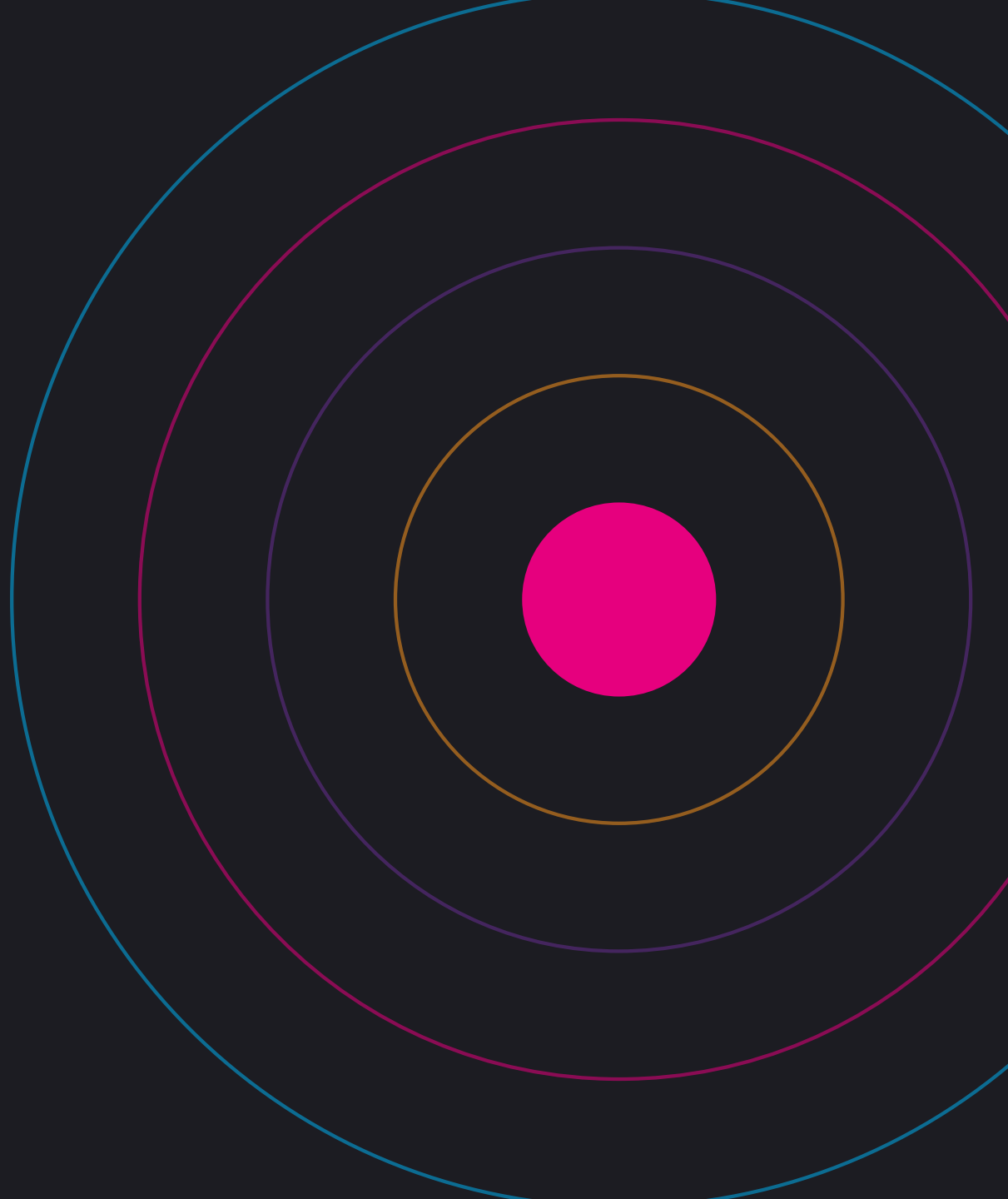
What Organisations Miss When Risks Are Managed in Isolation

Rosie Russell
Co-President, IIRSM
Director, EHS & Sustainability



What Organisations Miss When Risks Are Managed in Isolation

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Co-President, IIRSM
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THE PATTERN

Every risk was owned.
Every register was current.
Every function was compliant.

And it still happened.

Read almost any major incident report and this is the shape of it. Not ignorance — fragmentation.

HOW WE GOT HERE

We professionalised risk. Then we filed it.

1

Specialise

Risk gets its own experts — safety, quality, environment, security, finance, IT.

2

Systematise

Each discipline builds its own register, taxonomy, scoring scale and cadence.

3

Certify

Standards and regulators reward depth within a discipline, not across them.

4

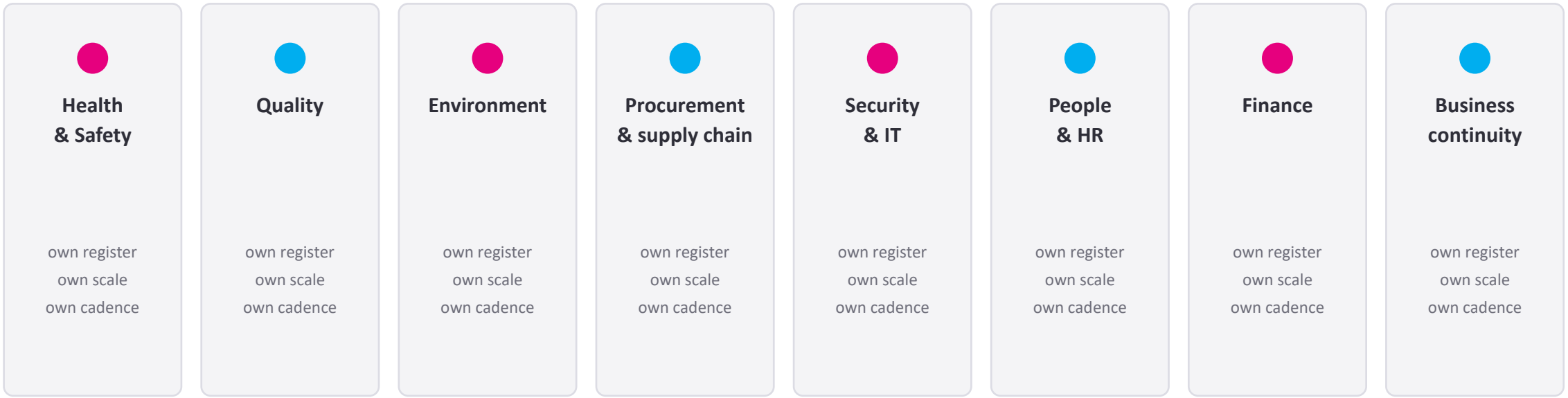
Insulate

Risk becomes something a function owns — and therefore something everyone else doesn't.

Each step was rational. The accumulated effect was not.

THE MODEL MOST OF US INHERITED

Eight registers. Eight languages. One organisation.



The gaps between these boxes are where organisations actually get hurt — and no one appears on an org chart as the owner of a gap.

BEFORE I GO FURTHER

Specialism isn't the enemy. Isolation is.

Depth

No generalist will ever know your process hazards, your data estate or your threat surface as well as your specialist does.

Assurance

Regulators, notified bodies and auditors need a competent, accountable point of contact. Depth is what earns licence to operate.

Standards

Disciplinary rigour is how good practice gets written down, tested and transferred. We shouldn't dismantle it.

Nothing here is an argument for fewer experts. It is an argument for fewer walls.

RISK DOESN'T RESPECT THE ORG CHART

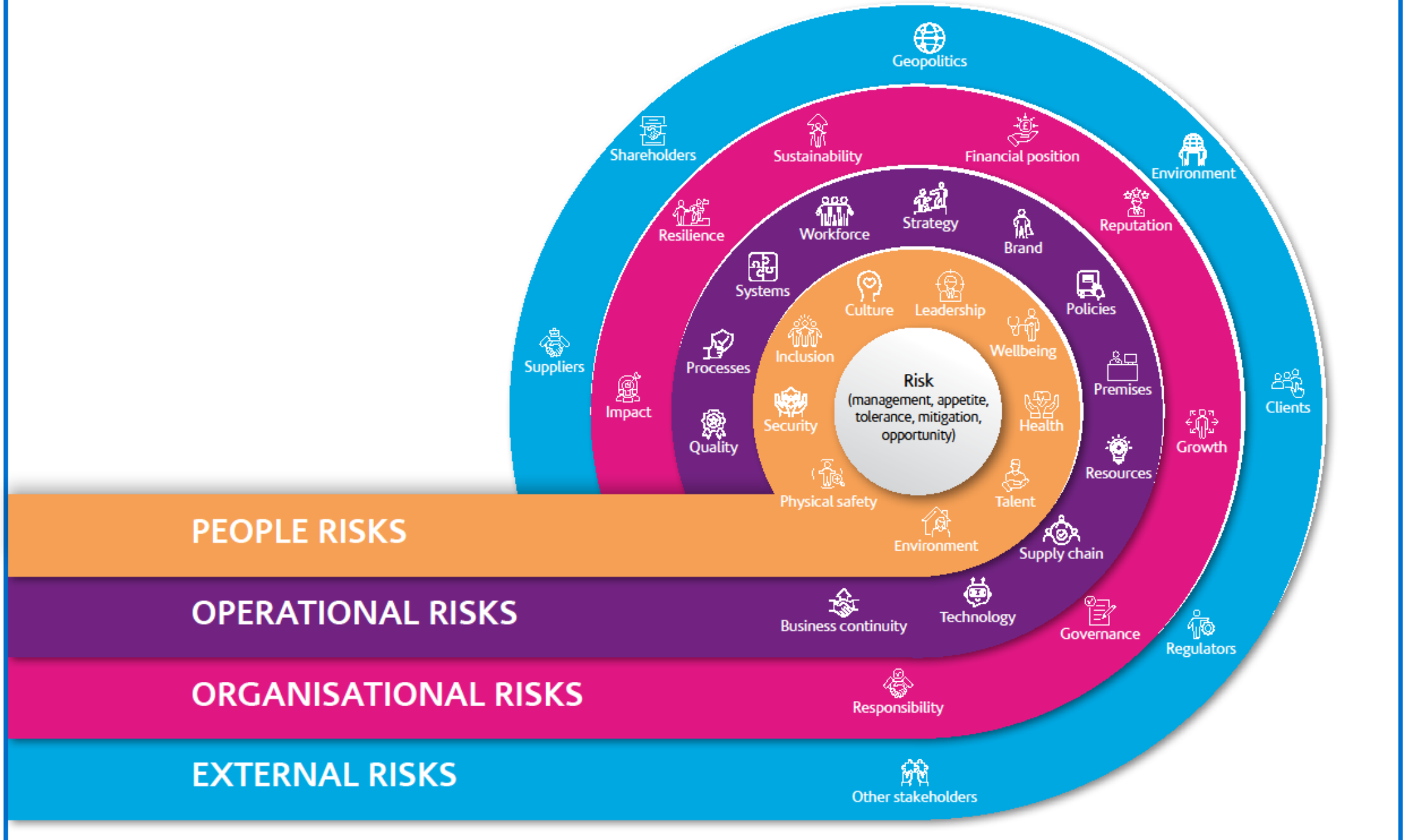
One risk is always four risks

- **People risks** — culture, inclusion, wellbeing, health, physical safety, talent, security
- **Operational risks** — processes, systems, quality, technology, supply chain, resources, premises
- **Organisational risks** — strategy, brand, reputation, governance, financial position, sustainability
- **External risks** — regulators, clients, suppliers, shareholders, geopolitics, environment



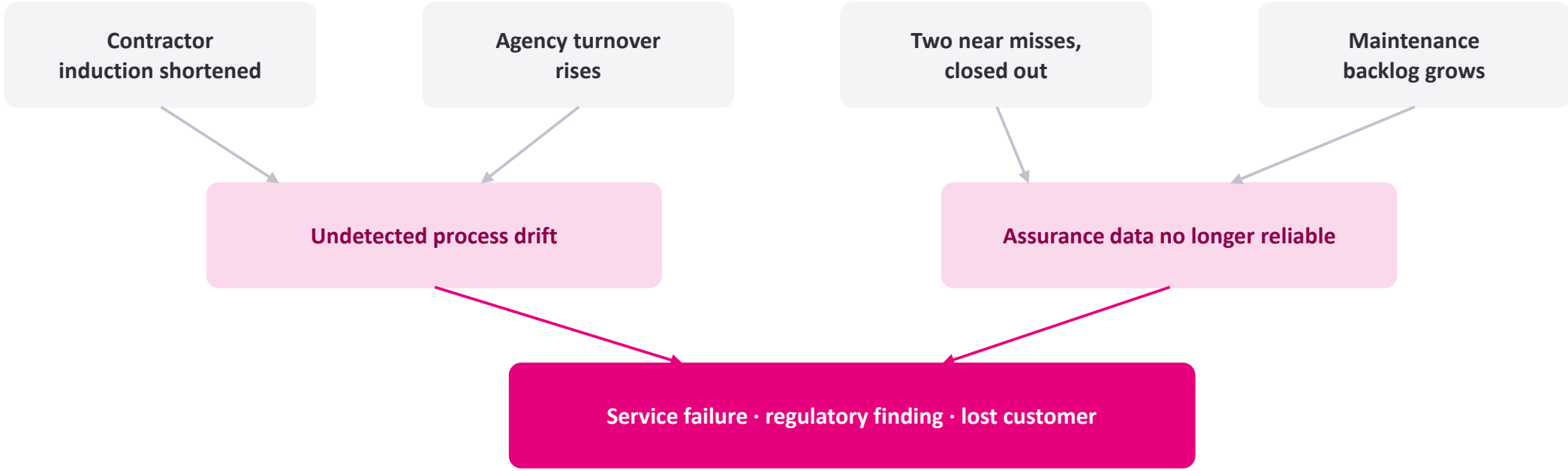
IIRSM Organisational Risk Map

iirsm ORGANISATIONAL RISK MAP



Small events that compound never reach the boardroom

Four unremarkable events. Four different functions. Each correctly assessed as low significance.



Individually: green. Collectively: the incident.

WHAT GETS MISSED · 02

Likelihood and severity are no longer enough

THE INHERITED MEASURES

Likelihood

Severity

Built for a world where risks arrived slowly, one at a time, inside a single discipline.

WHAT NOW ALSO DECIDES THE OUTCOME

Velocity — How fast it arrives. Covid and a ransomware event both went from zero to existential inside a week.

Connectivity — How many other risks it touches on the way through.

Reversibility — Whether you get a second attempt at the decision.

A siloed model can score the first two. Only a connected organisation can see the last three.

Silos see threats. Only the whole organisation sees opportunity.

One decision — invest in on-site renewable generation — read across four rings:

People	Operational	Organisational	External
New roles created	Energy independence	Sustainability targets accelerate	Positive coverage
Employer brand lifts	Downtime reduced	Resilience improves	New clients and investors
Engagement and productivity rise	Efficiency and cost savings	Financial stability	Valuation effect

Assessed by Environment alone, this is a capital request. Assessed collectively, it is a strategy.

WHAT GETS MISSED · 04

In almost every case, somebody already knew.

- It wasn't their register
- It wasn't their grade
- It wasn't worth the friction
- Nobody ever asked them

Every one of these is a design fault, not a character fault.

WHERE ISOLATION COSTS MOST

Your supply chain is everyone's risk and no one's register

HOW FAR YOUR ASSURANCE ACTUALLY REACHES

You

Tier 1 — Assessed, audited, contracted, scored

Tier 2 — Assumed to be doing the same

Tier 3 and beyond — Effectively invisible

Most disruption starts down here

ONE SUPPLIER DECISION, FOUR RINGS

People
Labour standards, key-person dependency, the safety of people you don't employ

Operational
Continuity, quality, lead times, single points of failure

Organisational
Reputation, sustainability reporting, financial exposure

External
Regulators, geopolitics, sanctions, customers who ask hard questions

40% of pandemic supply-chain disruption originated below tier one

1 in 6 organisations check a strategic supplier's continuity plan

One ordinary change. Six functions. No owner.

THE CHANGE

A supplier consolidates two sites into one to reduce cost.

Approved by Procurement. Correctly. On the information Procurement had.

Quality

Single point of failure for a critical raw material

Regulatory

Approvals and certifications were tied to the old site

EHS

New site, unassessed; audit programme built for the old one

Continuity

Recovery plan assumed dual sourcing

Finance

Saving is real; the contingency cost isn't modelled

Reputation

Customers who cannot be told to wait

No individual approval was wrong. The aggregate exposure was never assessed by anyone.

FROM MY OWN PANDEMIC

The simplest thing can bring you down.

And the solutions come from unexpected people…

…Hand Sanitiser…!

It was on no register

It was in no function's remit

It wasn't solved by anyone senior

Everything upstream of that moment was a supply chain nobody owned.

THE TEMPTING WRONG ANSWER

You cannot fix a connection problem with more centralisation

1

The map is not the territory

A consolidated register is a description of risk, produced monthly, by people not doing the work. Reality moves faster than the document.

2

Distance destroys signal

Every layer between the observation and the decision strips out the detail that made it useful. By slide 40 it's an amber dot.

3

Ownership becomes abdication

The moment a central function 'owns' enterprise risk, three thousand people stop feeling responsible for it.

Central co-ordination is necessary. Central ownership is not the same thing — and only one of them scales.

THE SHIFT

Everyone is a manager of risk

This is not a slogan. It is a design principle with four consequences.

- Risk competence becomes a core skill in every job description — not a specialism
- Risk conversations happen at the boundaries, not only at the top
- Challenge is treated as data, not as dissent
- Improvement is proposed by the people closest to the work

BUILDING BLOCK · 01

Fluency at every level — not expertise at one

Three domains of risk competence

Technical **Behavioural** **Business**

Most training programmes cover the first. Failures cluster in the second and third.

- **Technical**

  Organisational context · role of risk management · policy · projects · stakeholders · data · reporting

- **Behavioural**

  Influencing · emotional intelligence · collaborative · communicative · innovative · ethical · determined · systematic

- **Business**

  Governance and culture · financial integrity · supports society · compliance · supplier and partner management

Operational

Knows and understands. Identifies and acts on risk in day-to-day work. Escalates well.

Managerial

Applies knowledge. Sees interconnection across an area of responsibility. Influences culture.

Strategic

Reasoned advice under complexity. Shapes appetite. Aggregates. Drives culture.

Competence accumulates as people progress — so it has to start early, and it has to start with everyone.

BUILDING BLOCK · 02

Competence is worthless if it is not safe to use

Psychological safety is the belief that you will not be punished or humiliated for speaking up with ideas, questions, concerns or mistakes. — Amy Edmondson

IT IS NOT

- Being nice
- Always getting your way
- Freedom from discomfort
- Lower performance expectations
- Job security

IT IS

- Candour, constructive debate, respectful conflict
- Kind — respectful, caring and honest
- Honest feedback rather than agreement
- Being held to account and pushed to develop
- Freedom from harm

It does not have to come from the top. Teams can build their own — and often have to.

BUILDING BLOCK · 03

Decentralised decisions still need clear accountability

The informed captain model — how modern military and high-tempo organisations decentralise without losing control

1

Named decision-maker

One person is accountable for this decision. Not a committee.

2

Actively seek input

They are obliged to gather diverse perspectives — especially dissenting ones.

3

Decide, and show the reasoning

The decision is made openly, with the trade-offs visible.

4

Disagree and commit

Dissent is expected before; alignment is expected after.

5

Own the outcome

Accountability sits with the decision-maker, whatever the result.

Challenge is not a threat to the decision. It is the quality control on it.

BUILDING BLOCK · 04

Give people a shared map — then let them redraw it

A common language

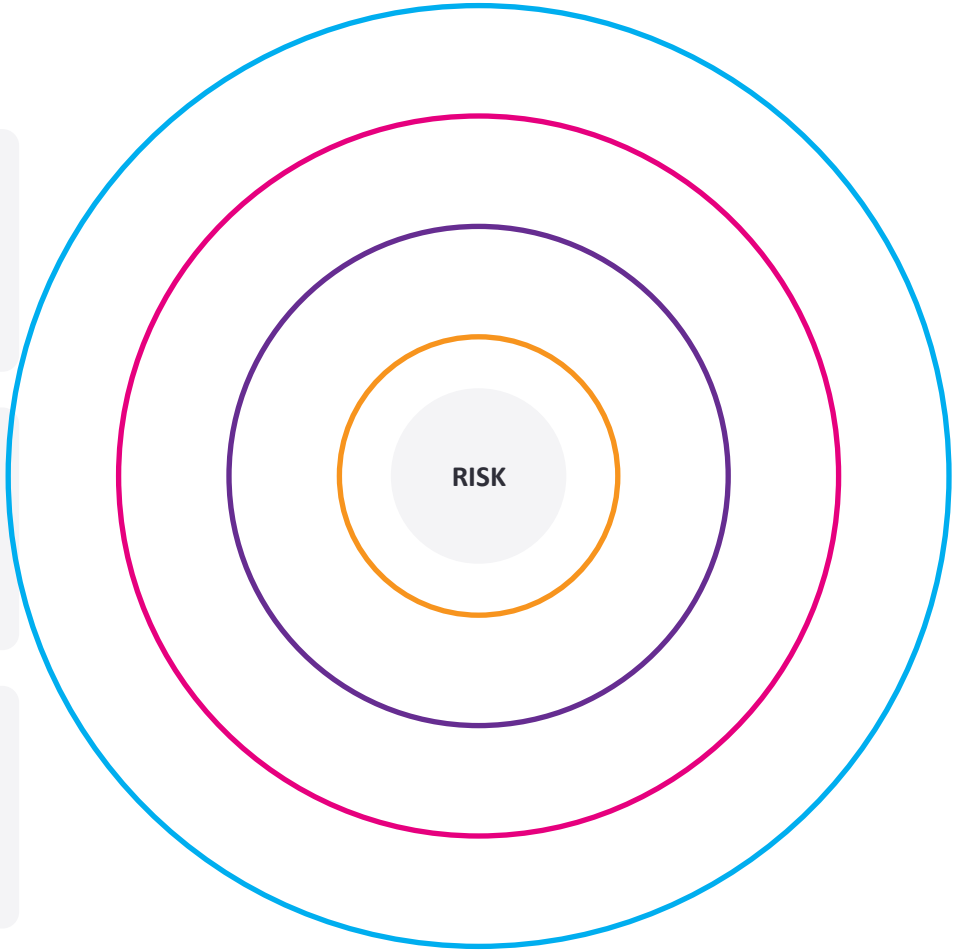
When a technician and a finance manager use the same four rings, a cross-disciplinary conversation becomes possible without a translator.

A prompt, not an answer

The map's job is to make people ask 'who else does this touch?' before the decision, not after the incident.

A local artefact

The generic map is a starting point. The value is created when your teams draw their own — and argue about it.



Draw yours.

THE JOURNEY

From collecting risk to connecting it

CENTRALISED & SILOED		DECENTRALISED & CONNECTED
Risk is owned by a function	→	**Risk is owned by everyone, co-ordinated centrally**
Registers per discipline	→	**One shared map, many local views**
Escalation upward	→	**Conversation across boundaries**
Challenge is friction	→	**Challenge is quality control**
Threats are recorded	→	**Opportunities are surfaced**
Competence is specialist	→	**Fluency is universal, expertise is deep**

Note what does not change: the depth of your specialists. Only their isolation.

PRACTICALLY

Five things you can start on Monday

1. **Ask how many registers you have**

   And whether a 'high' means the same thing in each of them. You may be the only person who can ask this question and get a straight answer.

2. **Commission the map workshop**

   Six functions, two hours, drawing how risk actually flows here. You don't need to attend. You do need to ask for it.

3. **Audit change and supplier onboarding**

   Compare who must be consulted with who is materially affected — for internal changes and for every new supplier. Close the gap.

4. **Add one horizontal forum**

   A standing cross-functional risk conversation with no chair from a risk function. Thirty minutes, monthly.

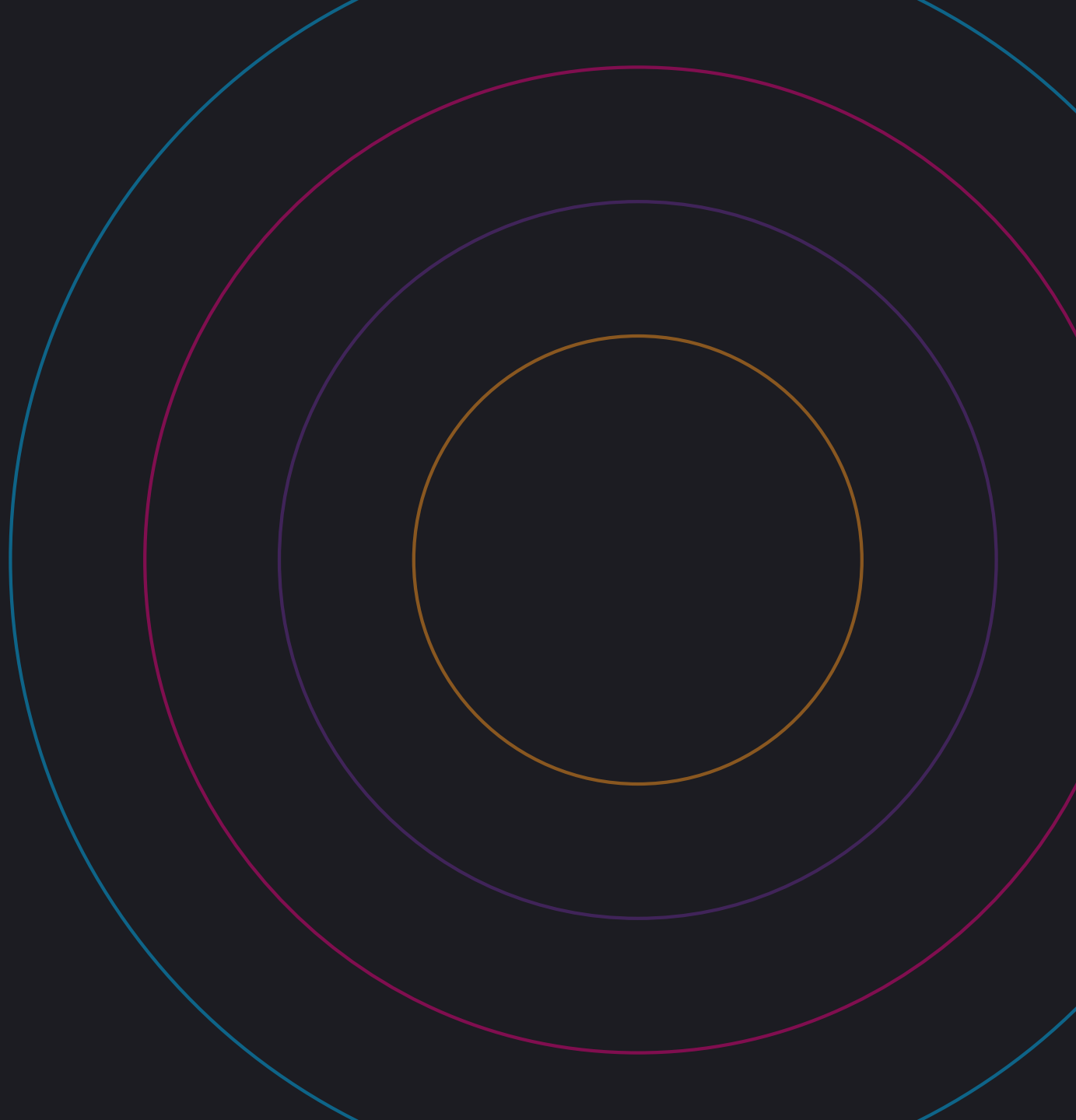
5. **Ask the four questions**

   Of anyone who hasn't escalated something: was it your register? your grade? worth the friction? did anyone ask?

None of these need a budget, a platform, or permission from a board.

THE QUESTION TO TAKE HOME

What is your organisation missing right now — and who already knows?



Somebody in your organisation can answer that.
Your only real job is to make it easy for them to tell you.
If you don’t ask, you will never know.
Until it’s too late…

Rosie Russell · Co-President, IIRSM · www.iirsm.org

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THE PERSON BEHIND THE DECISION:

From Opportunistic Theft to Organised Crime: The Changing Face of Shop Theft

Nathan Wilson · 09:45–10:25







The Changing Face of Shop Theft

BLUE DIAMOND®
Garden Centres





Retail Theft

- The data above is taken from the BRC Retail Crime Survey 2026. It highlights that Retail theft is on the increase and at levels never seen before in the UK.
- Violence and abuse have reduced but are still unacceptable.

Effects on Garden Centres

- Since Covid, there has been an increase in theft within the Garden Centre industry, largely led by other retailers being forced to close.

  Therefore, pushing the high street shoplifter into our centres and with the dramatic cost-of-living rises since Covid.

  We have seen more and more people looking at ways in which they can stretch their money.

- This has led to a number of different types of shoplifters:

1. Supporting a habit
2. Stretching their income / Pension
3. Need – Low Income
4. For the thrill
5. The Label Swopper
6. The entrepreneurial Shoplifter
7. Organised Crime Groups
8. Internal Theft

The Habit Funder



The Thriller: When asked why, the answer was “Something for Nothing”



The Label Swopper



The Entrepreneurial Shoplifter



Internal Theft / Fraud

Internal Theft is also on the increase due to a number of factors

- National living wage
- Have got away with it and continue to do it
- Feel let down by the company - didn't get that promotion or pay rise and see it as a way to take back what they believe is entitled to them
- See an opportunity and don't believe they will be caught
- 10% of staff will never steal from you
- 10% will steal from you
- 80% will steal from you if they see an opportunity and don't feel they will be caught

Some examples we have dealt with in Blue Diamond

- Refund fraud: Member of staff refunding onto their own debit card - £25,000. Prosecuted and found guilty; currently paying it back
- Refund Fraud - £110,000 prosecuted 18 months imprisonment
- Theft of cash - Prosecuted, currently paying it back
- Theft of Meat - Dismissed and paid back
- Fraudulently paying a member of staff for more hours than they work – Resigned and currently paying back
- Theft of cash to go on holiday - Resigned, prosecuted
- Gift card theft - Dismissed, paid back

Theft and Blue Diamond

SHRINKAGE

- 2022 = £1,9 M - 1.5% COS
- 2023 = £1,5M - 1.15% COS
- 2024 = £1,4M – 1%
- 2025 = £1M – 0.9% COS

DETERRENTS

- Staff Training - Theft & Conflict Management Workshops
- Eas Barriers and Tagging
- Upgrading the CCTV Systems in all centres with the introduction of ANPR and Facial Recognition
- Working with Local and National Police to implement crime reduction initiatives and tackle Organised Crime Groups

BIGGEST BENEFITS 2025

- With the introduction of ANPR, Facial Recognition and the improvement in the quality of CCTV, we are already seeing an increase in deters, arrests and prosecutions
- Positive hits on both vehicles and individuals are enabling store teams to meet and greet the offenders when they enter the centre and turn them away before they commit the act of theft, creating a safer work and shopping environment

Thank You

: nathan.wilson@bluediamond.gg

: 07971 886428



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REFRESHMENTS AND NETWORKING BREAK

10:25–10:50

Please return to this room for 10:50

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UNDER PRESSURE:

Why the Context of Work Matters as Much as the Rules

Professor Tim Marsh

Managing Director, Anker & Marsh · 10:50–11:25

Why People … Cock - Up !

Oct 2026



Anker & Marsh

google.com/search?q=who+is+the+world+expert+on+behavioural+safety&rlz=1C1GC

Google

who is the world expert on behavioural safety

AI Mode | All | Images | Forums | News | Videos | Shopping | More | Tools

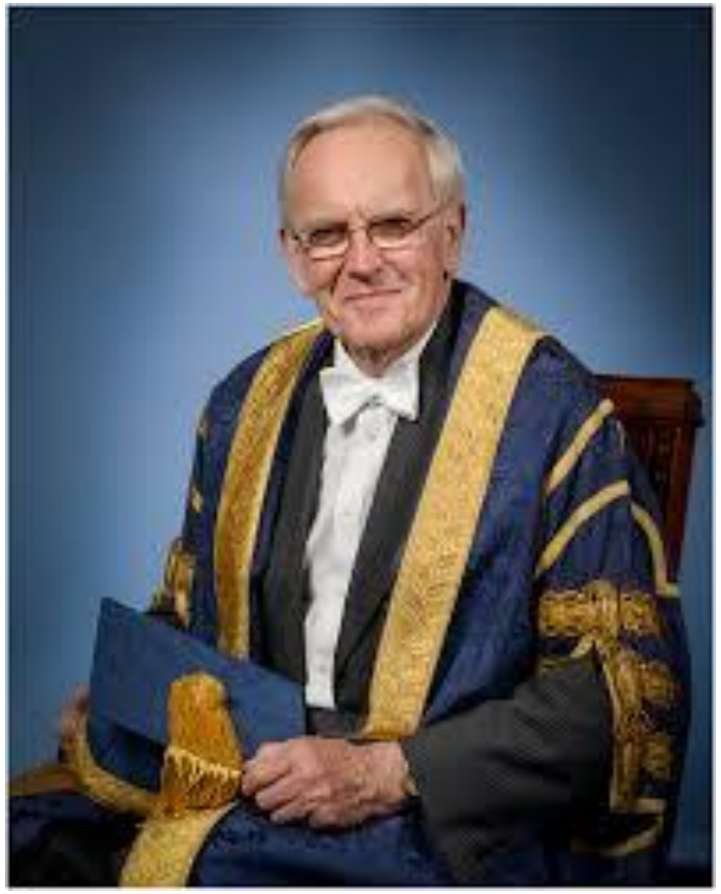
AI Overview

Professor Tim Marsh is widely regarded as a world-leading authority and expert on behavioural safety, safety leadership, and organisational culture. British Safety Council +1



Background and Expertise

The Lord, the Mayoress & the Bet …





.BET

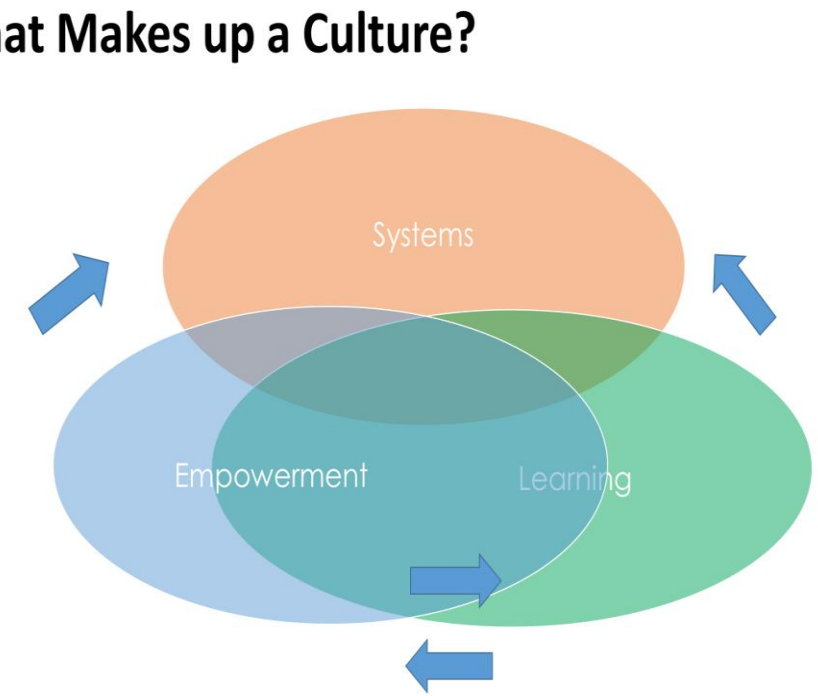
Anker & Marsh


Endorsed by IIRSM International Institute of Risk and Safety Management
"This book may change your life"
Lord Cullen
Total
Safety Culture
Organisational Risk Literacy
Dr. Tim Marsh
RYDERMARSH

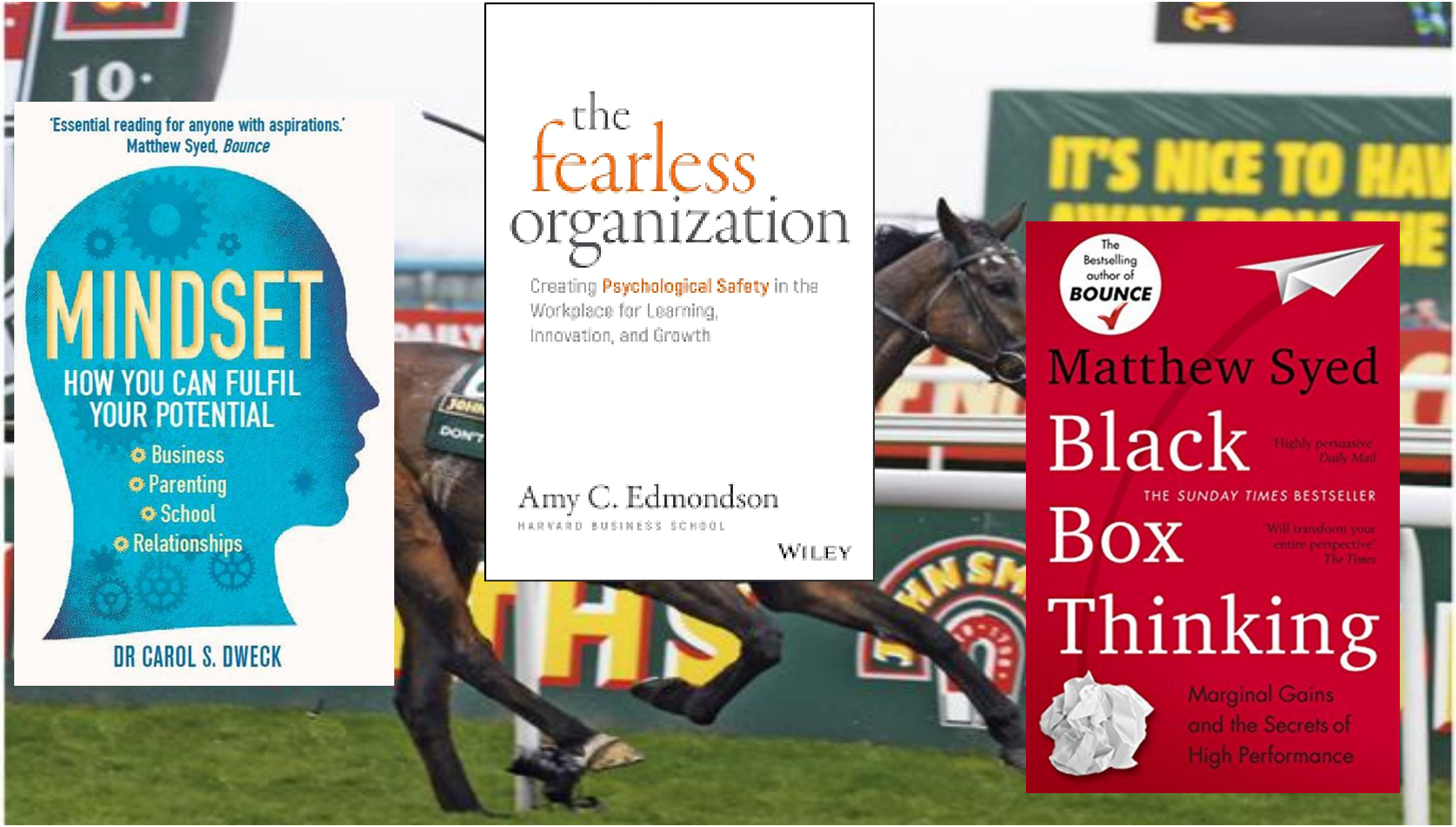
Anker & Marsh


GETTY IMAGES

The Jump Jockey With 3 World Records …






'Essential reading for anyone with aspirations.'
Matthew Syed, Bounce
MINDSET
HOW YOU CAN FULFIL YOUR POTENTIAL
Business
Parenting
School
Relationships
DR CAROL S. DWECK
the fearless organization
Creating Psychological Safety in the Workplace for Learning, Innovation, and Growth
Amy C. Edmondson
HARVARD BUSINESS SCHOOL
WILEY
The Bestselling author of BOUNCE
Matthew Syed
Black Box Thinking
'Highly persuasive' Daily Mail
THE SUNDAY TIMES BESTSELLER
'Will transform your entire perspective' The Times
Marginal Gains and the Secrets of High Performance





Why People Cock - Up !

Three Other Things …



Anker & Marsh



Marsh

An Intro to 3 - An Example of Excellent ‘Situational Awareness’ …



Anker & Marsh

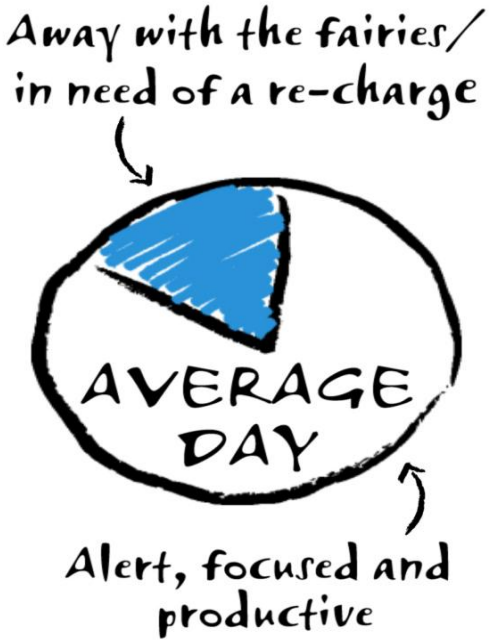


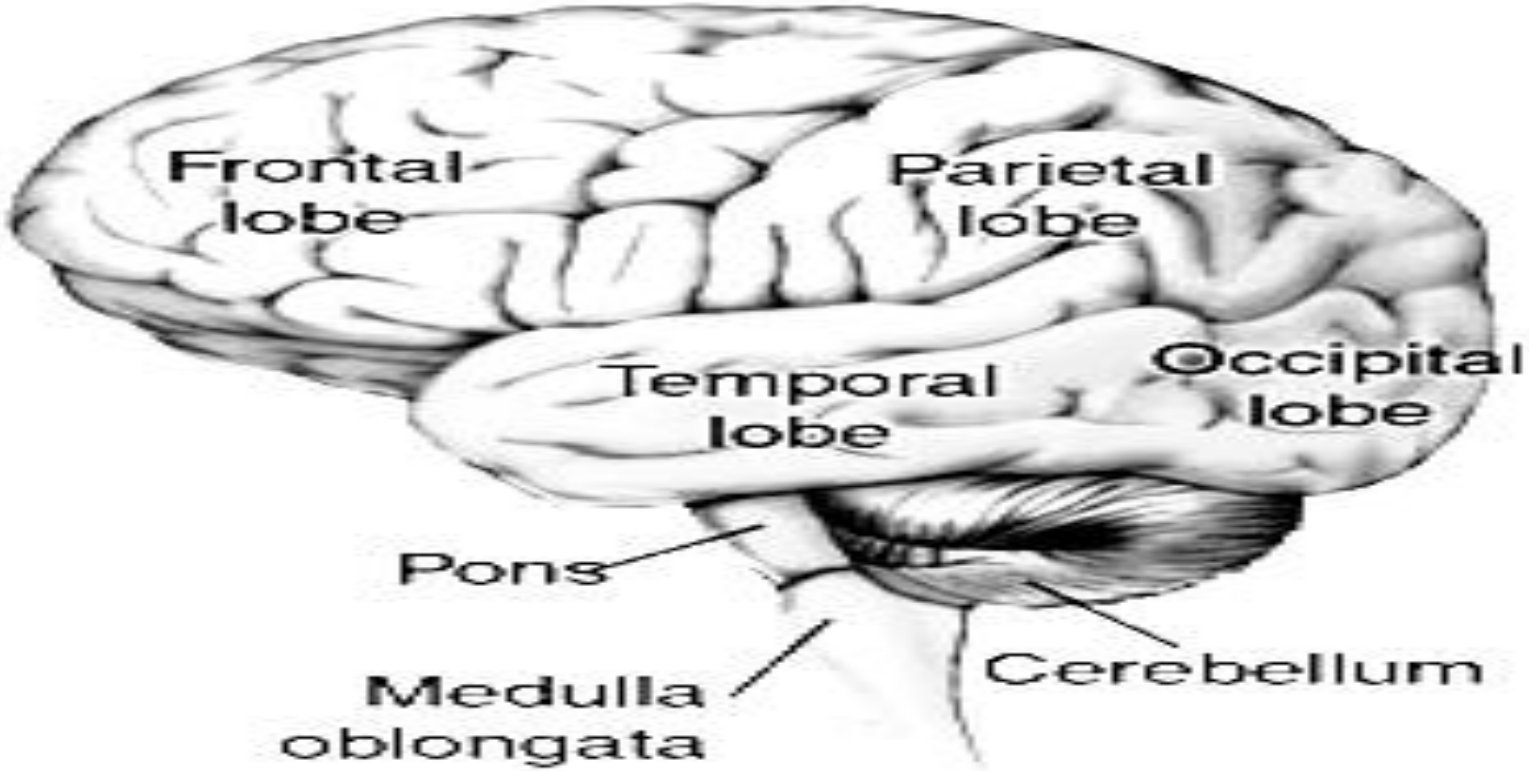


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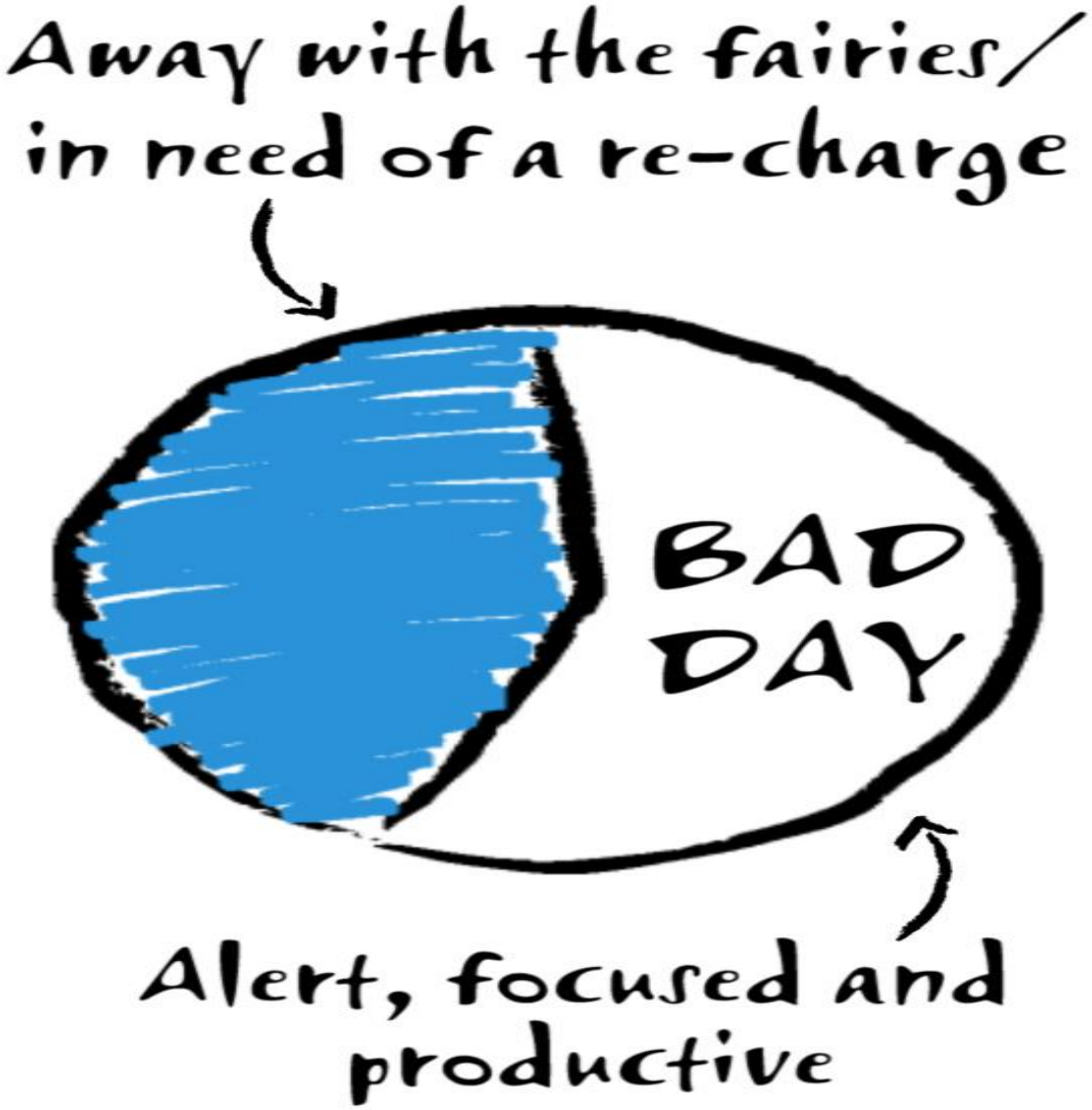
Anker & Marsh





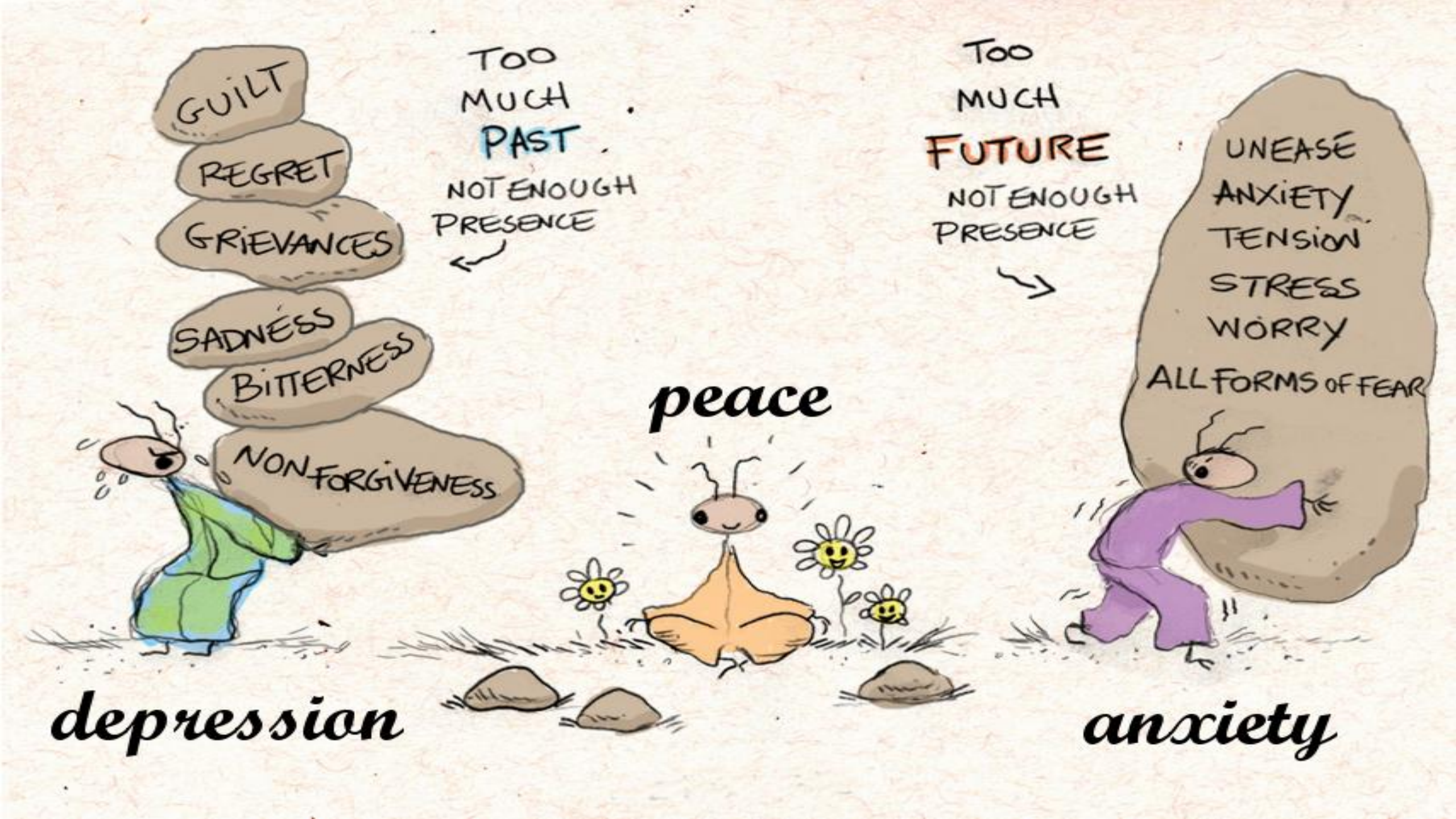
… and Housekeeping & Habits

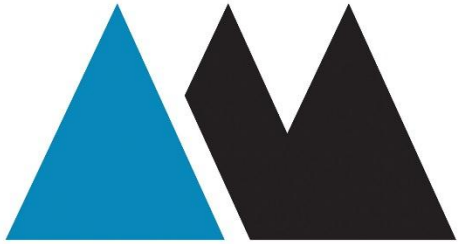
Anker & Marsh



But many people look far more like this …

Anker & Marsh


GUILT
REGRET
GRIEVANCES
SADNESS
BITTERNESS
NON FORGIVENESS
TOO MUCH PAST
NOT ENOUGH PRESENCE
TOO MUCH FUTURE
NOT ENOUGH PRESENCE
UNEASE
ANXIETY
TENSION
STRESS
WORRY
ALL FORMS OF FEAR
peace
depression
anxiety



Anker & Marsh

Thank You

info@ankerandmarsh.com

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RISK MANAGEMENT CONFERENCE 2026



CLIENT CASE STUDY:

Joining the Dots
How Better Risk Insight Changed a Business Decision

Richard True · 11:25–11:50

Joining the Dots…. Safety is more than just risk management

About me

Traditional Quality system in place but no system or structure for Safety or Environment - transitioned Quality system to ISO9001:2000 by stripping back and making it simple; saw the same structure could be used for safety, so started building in elements of Safety – ethos of keep it simple and build it in, not bolt it on.

- Management positions in the 80's and 90's helped me understand the operational side of the business.
- Quality highlighted silo mentality and narrow thinking and the need for integrated business systems.
- Safety taught me people - the mechanics are quite straightforward - legislation, interpret and document what to do - people turn that into a reality.
- Time has taught me to ensure proper engagement and listening; help people engage.

Polypipe

Linking the systems example: Integrated systems

Our site has ISO9001, ISO14001 & ISO45001 licences but 1 management system

- **PAS99 audits the integrated system**

1. Scope: what's in the standard
2. Normative References: what the standard has been based on
3. Terms and References: understanding the inevitable jargon
4. Context of the organisation: the world you operate it, who are your stakeholders
5. Leadership – commitment, policies, roles and responsibilities
6. Planning – What do you want to do and how you do it - objectives
7. Support – resource/competence/awareness/communications
8. Operation – how you do what you do – planning/controls/emergency planning
9. Performance Evaluation – how are you doing/audits/management reviews
10. Improvement – dealing with errors/accidents – prevent re-occurrence/continual improvement

There is no line between Quality/Safety/environment

Polypipe

Internal audits as a catalyst for change

- Fed up with completing internal audits ‘on’ a department or process but not getting any real ownership, actions agreed but not owned
  - Following year, same issues
  - Common across many departments
- Choice to be made - carry on doing the same thing or making the change
- Started small - what do the leaders need to make their life easier
- Started to build a management system to centralise and standardise what we do
- Applied quality thinking to safety systems
  - Keep it simple for the user and built it in so not more work, just making their work easier

Polypipe

Linking the systems example: Safe System of Work

- **Safe Systems of Work are a result of our Risk Assessments**
  - Leaders need to train their teams; SSW's give them a format, and linking to RA means local ownership from leader to complete Ra's
- **Train them out to appropriate departments**
  - Simple system that automatically adds people and SSW's to Skills matrix
- **Internal audits completed by leaders - measured KPI for all leaders to review 1 per month, in other areas**
  - Supports their understanding that they need to be reviewed
  - Supports their understanding of what happens in other areas
  - Visible commitment to teams that leaders are 'interested' in safety

Polypipe

Linking the systems example: 8D Incident management



RACI	Identifying key stakeholders and allocation of responsibilities (**R**esponsible/**A**ccountable/**C**onsulted/**I**nformed)
Is / Is Not	To clarify what the actual problem **is**, but also what it **is not** (allow context and define what needs solving)
Ishikawa	Identify possible causes (Structured brainstorm to look beyond the obvious)
5 Why	Identify Root causes (To focus on the problem not the symptoms)
PACE	To prioritise on the important issues to work on (**P**riority/**A**ction/**C**onsider/**E**liminate)
Action Plans	To capture actions and responsibilities and track progress (Important so that actions are not lost and verification done)

Introduced D zero –Triage

- Transformed the process from filling in the accident book to asking the right questions early and involving the right people
- Target time to complete triage within 4 hours

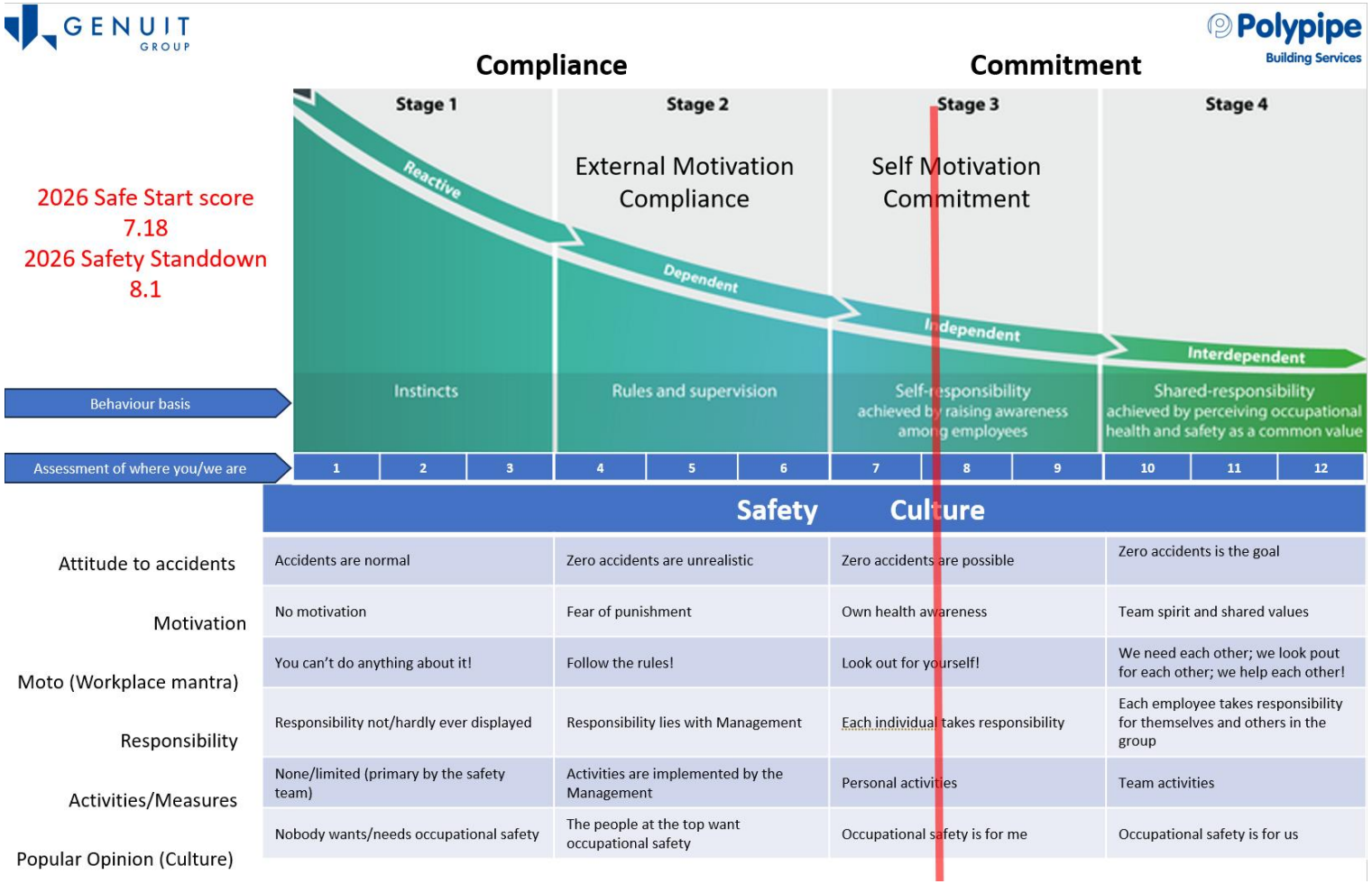
Polypipe

People and culture

- Often said, people are the most important asset, but is that really understood?

- Often said, we need a ‘good’ safety culture, but what is good and what are you doing about it?

- Safe Starts
- Positive conversations
- Safety Stand downs - local
- Safety Stand down - site wide
- Bradley Curve



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PANEL DEBATE:

Are We Managing Risks Individually While They Fail Collectively?

11:50–12:30

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LUNCH

12:30–13:30

Everyone returns to this room at 13:30

Human Factors in Practice

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HUMAN FACTORS IN PRACTICE:

Looking Beyond Individual Behaviour

Everyone together in this room · 13:30–14:45

Refreshment break follows until 15:05

15:05: specialist sessions

Aquatic Safety

Swimming pools and inland water

From Management System to Boardroom

ISO 31000 and stronger risk decisions

Supporting Colleagues in Crisis

Expert round table informed by BS 30480:2025

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THANK YOU FOR JOINING US