Near Miss Reporting
A Missing Link in Safety Culture

Publication Date: October 2013

The NASS Health and Safety Committee have agreed to undertake a new Safety Campaign to follow up the initial Three Year Plan. The Module will cover topical Health and Safety issues with two subjects per year to be covered and guidance provided. This is the first document to be produced under the Plan for 2013.

The content of this NASS Module is in line with advice from the Health and Safety Executive and Wolverhampton City Council the Lead Authority for Steel Stockholding and Service Centres.
INTRODUCTION

Near Miss Reporting or the lack of it is a controversial indicator of a Company’s Safety Culture. Identifying and investigating Near Misses are key elements to finding and controlling risks before employees are injured or property is damaged.

Why do some Companies struggle to make Near Miss reporting part of their Culture? The answer comes from a closer look at barriers which affect Near Miss initiatives and resistance that has to be overcome if this valuable tool is to be embraced.

This campaign briefly will seek to identify and clarify:

- What is a Near Miss?
- Why is Near Miss reporting important?
- What is required to embrace Near Miss reporting?
- How Safety Culture affects Near Miss reporting?
- What are the barriers to implementation and how can these be overcome?
- What are the benefits of Near Miss reporting?

Hopefully everyone reading this article will endorse the practical processes suggested to overcome resistance to Near Miss reporting as a useful tool to help reduce accidents in the workplace.
WHAT IS A NEAR MISS?

- A Near Miss is an unplanned event that did not result in an injury, illness or damage – but had the potential to do so.

- An event, circumstance, condition or behaviour which has the potential to cause injury, illness, accidental release or property/productivity loss – but did not actualise due to chance, corrective action and/or timely intervention. Other familiar terms for these events include “close call” or in the case of moving objects, “near collision” or “near hit”.

- Recording non reportable Near Misses is not a statutory requirement but in doing so and using the information provided is good safety Management practice as reviewing the report (at the time or periodically) may prevent a re-occurrence. Recording these Near Misses can also help identify any weaknesses in operational procedures, as deviations from normal good practice may only happen infrequently, but could have potentially high consequences. A review of Near Misses over time may reveal patterns from which lessons can be learned.

- Where a review of Near Miss information reveals that changes to the ways of operating, risk assessments or safety Management arrangements are needed, these changes should be put into effect.
WHY IS NEAR MISS REPORTING IMPORTANT?

Reporting and investigating accidents or incidents that have occurred is normally effective and efficient. Rather than simply applying such vigour to “after the event” situation, where somebody has actually suffered injury, the ideal is for everyone to be alert to the potentially unsafe or unhealthy situations and for preventative action to take place before anyone is harmed.

While formal risk assessments should have covered all foreseeable risks, danger always resides in the failure of day to day application of risk controls or an unexpected sequence of events. Hence a missing guard, a slippery patch, a shortcut to procedure or a failure to use protective equipment can create a potential problem in the most rigorously assessed operations.

“A CAUSAL FACTOR is a “human error” (typically an error by the at risk employee performing a task/job in the process) or a component fault/failure.

Note that these human errors or component failures are probably caused by other humans making mistakes, and all errors are controlled by the Management system. An incident typically has multiple casual factors; natural phenomenon can also be a causation factor.

A ROOT CAUSE is a Management system weakness that results in a casual factor. A casual factor typically has multiple root causes.
NEAR MISSES ARE **WARNINGS** THAT SOMETHING IS **NOT** WORKING AND ENABLES YOU TO LEARN LESSONS BEFORE A SERIOUS INCIDENT OCCURS, MAYBE INVOLVING YOU OR A COLLEAGUE.
Near Miss Reporting should help the Management / Supervision of a business to find trends and faults within their workplace system and provide the opportunity for more effective control measures to be introduced. Learning from Near Misses gives businesses the chance to “work at the bottom” of the classic Heinrich triangle which is shown below. This should provide Companies with more information to identify trends other than those identified from accidents without any one being injured.

By ignoring Near Misses, Companies are losing the free lesson in injury prevention. The few minutes spent reporting Near Miss incidents can help prevent similar incidents and even some severe injuries taking place.
In short by reporting Near Misses, learning from them, acting on information/trends should ensure everybody in the Company benefits from a safer working environment.

Furthermore Near Miss reporting improves the Safety Culture of a Company or Business by providing “trigger points” which if acted upon, reinforce the situation and provide Management with good basic disciplines. These include:

- A Near Miss in the workplace is a warning or indication that something is wrong
- Close call or Near Misses on the job should be corrected immediately
- Constant safety awareness on everyone’s part is the most important factor in accident prevention
- If you witness or are involved with a Near Miss incident, stop and correct the problem or notify the appropriate people immediately
- Do not just shrug off a Near Miss. Stop what you are doing and report it.
- Don’t have the attitude “that’s the way we have always done it”
THE IMPORTANCE OF REPORTING NEAR MISSES...

Some Near Misses are classed as 'Dangerous Occurrences' under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

An example of a “Dangerous Occurrence” in Steel Stockholding is failure of lifting equipment; dangerous occurrences should be reported to HSE.

More information can be found on http://www.hse.gov.uk/riddor/dangerous-occurrences.htm

Lifting equipment

The collapse, overturning or failure of any load-bearing part of any lifting equipment, other than an accessory for lifting

The definition covers the collapse or overturning of any lifting equipment, or the failure of any load-bearing part, whether it is used for lifting goods, materials or people. It does not cover the failure of ancillary equipment, such as electric operating buttons or radius indicators, or failures of lifting accessories, such as chains and slings.

Failure in this context refers to components which suffer mechanical breakdown during the normal operation of the lifting equipment, as opposed to accidental or deliberate damage.

Incidents involving cranes must be reported irrespective of the nature of the work being done, and reports must not be restricted to those involving lifting and lowering. For example, a collapse or overturning when a machine is being used for demolition activities must be included.

Lifting equipment includes machinery such as bored piling rigs and percussion piling rigs.
WHAT IS REQUIRED TO EMBRACE NEAR MISS REPORTING?

There is probably no perfect approach to monitoring or in fact embracing Near Miss reporting which relies upon subjective judgement and a constant willingness to act.

The approach to Near Miss reporting is very dependent upon the Safety Culture within a Company. The Safety Culture of a Company or Business is reliant on everyone within it “buying in” to principles and beliefs. If progress is to be made in developing a Safety Culture where everyone is alert to risky situations, it has the potential to make the greatest contribution to Health and Safety.

The Safety Culture of a Company can be defined as the “position on the Bradley Curve” in terms of how an employee is expected to behave. See the DuPont Bradley Curve Model below.

In an ideal world Companies should focus on a proactive approach to Near Miss reporting as opposed to a reactive approach.
For example a Culture of “obedience/reaction” would constitute an employee being *instructed* to report Near Misses as a “reaction” to a dangerous occurrence. The employee would make no decision as to whether this was the correct process to follow; instead they are likely to need instruction every time a dangerous incident occurs. This type of Culture requires “hands on” reinforcement from Management who must be aware of incidents in the workplace and be vigilant to support the practice of Near Miss reporting. If Management do not reinforce, employees will not report Near Misses.

A Culture of “dependence” would comprise of employees being instructed to report Near Misses by means of workplace *rules or procedures*. This creates a responsibility within the employee but Management must regularly check that the rules are being adhered to. For example, Management would not need to instruct an employee to report a Near Miss; a rule would create the need to report a dangerous occurrence through a familiar reporting procedure. Management must have processes in place to check that the rules are being followed, correctly, and are more likely to ask an employee what has been done than instruct an employee to act.

A Culture of “independence” is one where employees are aware of their responsibilities to their job role and to themselves, they are aware that a Near Misses should be reported when a dangerous incident occurs and make the decision to comply based on an “automated” response to an incident, as a consequence of Safety Culture being *logically understood* and supported. Management have less of a role to play, but must instead work on the “logical understanding” of workplace safety and encourage slightly more “proactive” behaviour from employees.

A Culture of “interdependence” encompasses proactive Safety Culture as part of normal business. Employees are *aware* of the safety of all employees and this would therefore compel them to report Near Misses in an effort to keep high safety standards. Management would be informed of reporting trends and would make analysis as to the changes need to be made to limit the danger.
The majority of Companies will probably be covered by the Reactive /Dependant type of Culture and hence the characteristics of success in implementing policy change should be noted. Irrespective of the behaviour and Safety Culture of employees, the onus is on Management to drive the desired result!

The owners/managers of Companies have a very important role to play in Near Miss as they create the environment in which business will operate and their actions set the precedent. Hence top Management should be seen as visually committed to the process and furthermore actively sponsor and encourage involvement. It is also important to recognise that being committed to a process is not enough.

**MANAGEMENT WILL BE REQUIRED TO DEFINE EXPECTATION, PROVIDE TRAINING, DEFINE HOW PERFORMANCE WILL BE MEASURED AND RECOGNISE OUTCOMES IN TERMS OF “REWARD” TO PARTICIPANTS OF THE NEAR MISS REPORTING PROCESS.**

If the Management of a Company or business want to encourage employees to take time out of their busy schedules to create Near Miss reports, then they need to consider utilising a simple and straight forward reporting system. *(Some examples are shown in Appendix 1).*

Management must not fall into the trap of making the process too complicated or allow it to overlap with other initiatives or Safety Schemes already in place. Any overlap is likely to create confusion and lose sight of the purpose of Near Miss reporting. The forms should not be too long or complicated and should only focus on information needed to promote action.

The next stage in the process is to ensure the concept of Near Miss reporting is understood and known to everyone in the Company. The more difficult task is getting everyone to adhere to the reporting process and encouraging a mandatory response to every incident, irrespective of how minor the situation may be.

If Near Miss reporting is to be positively adapted then everyone; - managers, supervisors and employees need to be educated so that a red light goes off in their heads when they witness a Near Miss.
Employees must understand that the same conditions, unless addressed, are likely to result in future incidents and that the next time it might lead to actual amputation, broken bones, head injuries or even fatalities.

“Employees need to understand that the situation might not be addressed unless they report it!”

Further information on the subject of Behaviour was published by NASS as a Focus of the Month in October 2012. Please refer to the NASS website for more information or follow the link below:


EMPLOYEE TRAINING...

Safety is everyone’s responsibility, so it makes sense that every employee in the Company receives appropriate training and is shown how easy and quick it is to complete a report. It will also be important to stress the relevance of Near Miss reporting and by giving some examples of Near Miss situations hopefully they can recognise the benefits to all concerned.

The employee training should focus on:-

- Why are Near Misses important and how they can help?
- What is the role of each person in Near Miss reporting?
- How will Near Misses be managed and by who?
- What is the Near Miss process (eight steps)?
- How do you report a Near Miss?
- How would you prioritize a Near Miss?
- Where to find Near Miss reporting forms?

ANALSING RESULTS...
Collating reports and not acting upon them is a waste of everyone’s time, but it could also mean that the safety of employees is being put at risk. It is paramount that Management do not allow Near Miss reports to disappear into a “black hole”. There is nothing more discouraging than taking time to complete a report and to receive no feedback or recognition of the event.

The reviewing of Near Misses, action taken and subsequent methods of working should be undertaken by Management and employees in the form of Safety Committees or in the most basic situation with workplace representatives. The lack of feedback and/or action is likely to “kill” the opportunity to embrace Near Miss reporting.

Ideally Near Miss investigations should be open and the findings reported back to everyone. This creates the perfect opportunity for Management/Supervision to advise employees of any changes to policy/procedure as a result of the investigation.

Communication of findings on Notice Boards and on the Company intranet is likely to generate the sense of importance of the scheme. It is important that Management see Near Miss reporting as a learning opportunity and a positive manner to reinforce continuous improvement in safety and business performance.

WHAT ARE THE BARRIERS TO IMPLEMENTATION AND HOW CAN THEY BE OVERCOME?
Many Companies understand the importance of Near Miss reporting as an accident reduction technique. However putting in place a Near Miss procedure is just one element of a successful Near Miss reporting system.

A Near Miss reporting procedure can be incorporated within a Company, the agreed forms distributed to employees and the communication undertaken to tell everyone what is expected of them. However this does not mean that Near Misses will be reported.

Employees are often reluctant to report Near Misses. There are a number of barriers that can be present within any business that prevents Near Misses from being reported. These potential obstacles, can, if not addressed generate a negative or apathetic response from employees which is the converse to the devised enforcement of a positive Health and Safety Culture.

Barriers preventing employees from reporting Near Misses can vary, but the most common relate to:

- LACK OF MOTIVATION
- WORK PRESSURES
- LACK OF UNDERSTANDING

The LACK OF MOTIVATION of employees is often directly connected to:
A FEELING THAT **NOTHING IS DONE** ONCE A NEAR MISS IS REPORTED,

**NOTHING IS GAINED** PERSONALLY OR AS A COMPANY FOR REPORTING THE NEAR MISS,

**NO ONE IS ASSIGNED TO TAKE** OWNERSHIP **OF THE PROCESS AND NO VISIBLE ACTION** IS TAKEN IN RELATION TO THE NEAR MISS REPORTED.

If nothing is seen to be done, once a Near Miss has been reported, why would an employee bother taking the time to make another report? This can happen even when action is taken, but the action is not effectively communicated back to the workforce.

One of the ways of resolving this situation is to identify Managers/Supervisors responsible for addressing Near Miss reports and taking action. This does not necessarily mean that the same people undertake this responsibility; the task can be resourced on a rotation basis amongst the Management/supervision to ensure that its visibility is evident for all top Management and also provides fresh impetus, which is key, if the process is to be sustained.

The feedback from actions taken is also paramount; Companies need to review the most effective manner in which this can take place.

The setting of targets, measuring results and communicating positive results such as a reduction in accident figures should also be incorporated in briefings which recognise and thank the workforce for getting involved.

**WORK PRESSURE** is a major excuse for Near Miss reporting not taking place or being embraced by the Company and its workforce. A blame Culture associated
with Health and Safety can undermine the success of Near Miss and indeed accident reporting. If someone feels they may be to blame for a Near Miss they may avoid reporting through fear of a penalties.

Typical work pressure reasons for failure to report are:

- **CONCERN THAT SUPERVISORS WILL HOLD THE NEAR MISS AGAINST THEM OR APPORTION BLAME,**

- **CONCERN THAT OTHER WORKERS WILL VIEW THEM AS A “GRASS” OR “SNITCH”,**

- **FEAR OF JOB LOSS OR PENALTIES IF THEY FEEL THEY COULD BE BLAMED AS A CONTRIBUTING FACTOR.**

Supervisors discouraging employees to report Near Misses because it may reflect badly on the department and “just get back to work” creates a negative impact on the process. In fact, it may also be directly related to how they feel they may be perceived by Management. In reality it is a sort of “defence mechanism” to protect their own status at the expense of employees.

(There are different approaches to resolving this situation which are shown in the Reporting Methods shown in Appendix 2.)

In summary, Near Miss reporting systems should ideally be penalty free. This could be achieved by anonymous reporting; although this loses credibility if a review of incidents cannot be undertaken with actual witnesses. Management here is encouraged involvement by demonstrating support for the process. Eliminating the Blame Culture is important as everyone seeks to improve safety in the workplace.

The **LACK OF UNDERSTANDING** is a poor and feeble excuse both for the Management and employees of a Company, the use of lengthy report forms and use of technical terms and phrases will have a negative impact on Near Miss
reporting. It is important to gather information to assess Near Misses and take action, but sometimes it is better to get some information than nothing at all. Typical reasons for Near Miss reporting failures due to a lack of understanding can be:

– **EMPLOYEES DO NOT KNOW WHAT A NEAR MISS IS OR WHY IT IS IMPORTANT**

– **EMPLOYEES ARE UNSURE HOW TO REPORT NEAR MISSES AND WHO TO REPORT THE SITUATION TO IN THE COMPANY**

– **NEAR MISS REPORT FORMS ARE TOO COMPLICATED AND LENGTHY**

These can be summarised by employees deciding whether to take time out of their day to try to fill in forms which they are not sure will generate benefit and have other pressuring deadlines to meet. In short, if the importance of reporting Near Misses has not been communicated and understood prior to introducing the reporting system, why would employees waste their time?

However if Management raise awareness of the relationship between Near Misses and accidents, and how Near Miss reporting will help reduce risk and potential accidents, then employees can identify purpose and hopefully see the benefits for all involved with a safer workplace being encouraged.

To encourage employees will have Companies adapting whichever approach fits within their Culture and generates a feeling of teamwork and togetherness in striving for a safe and healthy workplace. The barriers identified above are, in the main, generalisations but provide the reader with points to note if they are not currently successful in embracing Near Miss reporting.

**WHAT ARE THE BENEFITS OF NEAR MISS REPORTING?**

Alternative views on this subject can be seen in Appendix 3
Every Company or business would ideally like to have a system in place which prevents workplace injuries, equipment damage and creates a safe and healthy workplace.

If Near Miss reporting can be fully embraced by a Company then it moves a long way to achieving that goal and provides additional benefits which include:

- **IT ENABLES COMPANIES TO PROACTIVELY RESOLVE HAZARDS BEFORE A TRAGIC OR COSTLY INCIDENT OCCURS**

- **IT ENGAGES THE WORKFORCE (ALL EMPLOYEES AT ALL LEVELS) IN SOLVING PROBLEMS**

- **IT INCREASES SAFETY OWNERSHIP AND INCREASES SELF ESTEEM**

- **IT EXPOSES VALUABLE INFORMATION THAT OTHERWISE MIGHT NOT BE DISCUSSED**

- **IT DEVELOPS A POSITIVE AND NECESSARY ATTITUDE TO SURROUNDING SAFETY**

The role of Supervisors in Near Miss reporting should not be underestimated. They must be seen to embrace, educate and raise awareness to ensure that the system can be sustained.

To help the process a checklist of how to identify and analyses Near Miss Incidents is shown in Appendix 4.

THE “CLOSING OUT” OF A REPORTED NEAR MISS NEEDS TO BE MANAGED AND MONITORED OTHERWISE YOU RUN THE RISK OF A BUILD-UP OF DATA THAT FALLS INTO A “BLACK HOLE” OF INACTION.
## ROLES AND RESPONSIBILITIES OF MANAGEMENT FOR NEAR MISS REPORTING

<table>
<thead>
<tr>
<th>Role</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appointing a senior manager to carry out investigations.</td>
<td></td>
</tr>
<tr>
<td>Participation – or nominating a member of staff to participate – in investigations</td>
<td></td>
</tr>
</tbody>
</table>
| Ensuring that staff are aware of the need to report Near Misses      | Advise on, monitor and encourage reporting of Near Miss Occurrences.  
| Advise staff about the need to report Near Misses.                  |                                                                                                                                             |
| Ensure that employees enter near misses onto the local accident     | Reporting system as appropriate.                                                                                                           |
| reporting system as appropriate                                      |                                                                                                                                             |
| Monitoring trends from near miss reporting data                      |                                                                                                                                             |
| Ensure reports involving their staff or activities under their      | Investigated as appropriate and Near Miss report forms completed.  
| control are investigated as appropriate and Near Miss report forms   |                                                                                                                                             |
| completed                                                           |                                                                                                                                             |
| Maintain statistics on all reports, reporting them locally at        | E.g., at safety committees and as part of annual reviews.                                                                                      |
| regular intervals                                                   |                                                                                                                                             |
| Ensure that employees enter near misses onto the local accident     |                                                                                                                                             |
| Reporting system as appropriate                                      |                                                                                                                                             |
| Review all reports made on the local reporting system and ensure    |                                                                                                                                             |
| progress is made on their investigation                             |                                                                                                                                             |
| Become involved in investigations as appropriate                     |                                                                                                                                             |
| Agree any actions necessary to prevent recurrence with relevant     |                                                                                                                                             |
| staff and the Safety Advisor                                        |                                                                                                                                             |
| Ensure actions to prevent recurrence agreed in reports are assigned,| According to any agreed timelines.                                                                                                           |
| reviewed and completed according to any agreed timelines            |                                                                                                                                             |
| Agree actions and sign off or close out all reports                 |                                                                                                                                             |

### IN CONCLUSION

- Participation – or nominating a member of staff to participate – in investigations.
- Ensuring that staff are aware of the need to report Near Misses.
- Advising on, monitoring, and encouraging the reporting of Near Miss Occurrences.
- Ensuring that employees enter near misses onto the local accident reporting system as appropriate.
- Monitoring trends from near miss reporting data.
- Ensure reports involving their staff or activities under their control are investigated as appropriate and Near Miss report forms completed.
- Maintain statistics on all reports, reporting them locally at regular intervals.
- E.g., at safety committees and as part of annual reviews.
- Review all reports made on the local reporting system and ensure progress is made on their investigation.
- Become involved in investigations as appropriate.
- Agree any actions necessary to prevent recurrence with relevant staff and the Safety Advisor.
- Ensure actions to prevent recurrence agreed in reports are assigned, reviewed, and completed according to any agreed timelines.
- Agree actions and sign off or close out all reports.

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Near Miss Reporting as an Analysis of Accidents  
The National Association of Steel Service Centres  
October 2013
It is possible to get Near Misses reported but Companies have to recognise and address each barrier that presents itself. Reducing the fear of discipline is most important and various steps may need to be taken in order to achieve success.

However, it cannot be stressed enough, a positive, visible and committed Management attitude is essential to give the process any chance. Near Miss reports should be an agenda topic on all Management meetings that incorporate safety.

When Near Miss reporting has been accepted, sustaining momentum will always demand workforce commitment, any lack of focus will inevitably jeopardise the process.

The benefits of embracing Near Miss reporting can be life changing and therefore all the pitfalls which have to be overcome are worth it to secure and accident free workplace.

“Today’s Near Miss could be tomorrow’s fatality”
Examples of Near Miss Report Forms

Reporting Methods for Near Miss Reporting

Alternative views of presenting barriers to implementing Near Miss reporting

Checklist for identification and analysis of Near Miss Incidents

Management Investigation Forms

References

Health and Safety Executive
AALS Inspector Guidance Note – IGN 1.08

1) HSL Research Report provides background information & a Near Miss Reporting form

2) ‘Dangerous Occurrences’ RIDDOR –
   http://www.hse.gov.uk/riddor/dangerous-occurences.htm

3) A ROSPA report to HSE on worker involvement for Near Miss.
   http://www.hse.gov.uk/involvement/rospa-wish.pdf

4) How the industry stakeholder set about aims/objectives/targets etc
   http://www.hse.gov.uk/paper/pabiac-strategy.htm

5) Investigation issues once near miss reporting is introduced
   http://www.hse.gov.uk/managing/delivering/key-actions/accident-incident.htm

6) Near Miss Worker Involvement
   http://www.hse.gov.uk/involvement/
Appendix 1

Near Miss report form

NEAR MISS REPORT

A near miss is a potential hazard or incident that has not resulted in any personal injury. Unsafe working conditions, unsafe employee work habits, improper use of equipment or use of malfunctioning equipment have the potential to cause work related injuries. It is everyone’s responsibility to report and/or correct these potential accidents/incidents immediately. Please complete this form as a means to report these near-miss situations.

Department/Location Date:

Time _______ □ am □ pm

Please check all appropriate conditions:

□ Unsafe Act

□ Unsafe Condition

□ Unsafe equipment

□ Unsafe use of equipment

Description of incident or potential hazard:

__________________________

__________________________

__________________________

__________________________

__________________________

__________________________

Employee Signature Date (optional)

NEAR MISS INVESTIGATION

Description of the near-miss condition:

__________________________

__________________________

__________________________

Causes (primary & contributing)

__________________________

__________________________

__________________________

__________________________

__________________________

__________________________

Corrective action taken (Remove the hazard, replace, repair, or retrain in the proper procedures for the task)

__________________________

__________________________

__________________________

__________________________

__________________________

__________________________

Signed: Date Completed

Not completed for the following reason:

__________________________

__________________________

Management Date
Appendix 1 (cont.)

Accident, Incident or Near Miss report form

When to use this form
1. To report any Accident, Incident or Near Miss
2. This form should be completed by the person involved, forwarded to their immediate supervisor or the supervisor of the area where Near Miss is identified or the incident occurred for review and action. A report is required for each injured party if more than one person is injured.
3. The supervisor should complete the form if the person involved is unable to do so.
Appendix 2

Reporting Methods

The different approaches could involve:

- **VERBAL REPORTING AS THINGS OCCUR**
- **VERBAL REPORTING IN TEAM MEETINGS**
- **REPORTING CARDS**
- **REPORT BOOK**
- **ELECTRONIC OPTIONS**

The reader may consider the positives and negatives of encouraging people to use these options. Working Cultures vary and may be suited to different procedures.

**TO SIGN OR NOT TO SIGN**

Where a written procedure such as a reporting card is used, the questions must be considered as to whether it should be anonymous or signed and how issues are to be reported in relation to the failings of individuals.

Certain types of report can create difficulty and lose credibility if not signed. For example, a report of a pot-hole on a roadway with insufficient detail to enable it to be located may discredit the process. However, people may be deterred from reporting a behavioural issue such as the persistent non-compliance with a procedure if they feel they have to put their name to it.

A further dynamic that cannot be ignored is that an unpleasant atmosphere may be created if people are giving reports naming individuals, whether signed or unsigned. While logically there is no excuse for an unsafe act or omission, the fact should not be ignored that team co-operation can be damaged by ill-feeling that arises from such situations and that people may form conclusions that go beyond the issue itself.
Appendix 2 (cont.)

Reporting Methods...

It is proposed that the emphasis be placed upon ‘underlying learning’. This does not discourage immediate action where it is justified, but seeks to identify ways of achieving permanent improvement rather than simply 'quick fixes'. The introduction of a possible process and reporting format is shown below.
Reporting Methods...

Hazard report card

Above is shown a possible format for a report card, which should be made easily available with 'post boxes' for submission. The principle is to keep the format as simple and easy to use as possible. The explanation and encouragement on how to use the process should come from the manager in introducing and subsequently supporting the initiative, perhaps through 'toolbox talks'.

There have been successful examples of such reporting being combined with other local requirements, but this risks losing the emphasis upon safety and may only work well where the workforce has been closely involved in developing a system that suits them. The use of such a card rather than relying upon verbal reports is to give confidence to people that the issue has been recorded and to provide a means of identifying behavioural lapses without seeming to 'shop' individuals.
appendix 2 (cont.)

reporting methods...

managers hazard board

<table>
<thead>
<tr>
<th>hazard type</th>
<th>no of reports</th>
<th>action to date</th>
</tr>
</thead>
<tbody>
<tr>
<td>guard missing on exaumer 3</td>
<td>2</td>
<td>priority fitter job ordered 05/07 – guard repaired and replaced 06/07. All fitters reminded of priority</td>
</tr>
<tr>
<td>no high vis - visiting driver</td>
<td>5</td>
<td>spoke and written to manager of transport company 07/07 - turn back drivers without PPE in future</td>
</tr>
<tr>
<td>oil spill</td>
<td>1</td>
<td>barrier and signs in place 17/07. Clean-up ordered - Cleaned 18/07. Cause under investigation</td>
</tr>
<tr>
<td>pipe fell from site near driver</td>
<td>1</td>
<td>refitted and tested immediately 20/07. Warning notice to be put up. All high structures to be checked</td>
</tr>
<tr>
<td>seat belt not worn in forklift</td>
<td>2</td>
<td>reminder issued to all personnel 20/07 - this is a disciplinary offence</td>
</tr>
</tbody>
</table>
A Hazard Board shows a possible approach to demonstrating the Management response to reports, which must be prompt, include everything and be seen to be addressing the root causes of issues as far as possible. This particular method adopts a customised white board that may be displayed in the rest room or other frequently used space, but sites are encouraged to give thought to their local approach as a locally-derived procedure is often more likely to be effective.

Over time, recurring events are likely to emerge that justify in-depth study. Wherever possible, members of the workforce should contribute to such an investigation as this both introduces an important working perspective and builds commitment to the proposed solutions. For example, consistent non-use of an item of personal protective equipment or non-compliance with a system of work may be revealed to have particular underlying reasons such as discomfort or ineffectiveness. Alternatively, there may be a need revealed for Management to explain better why the approach has been adopted in the first place.

The display period (here showing fictitious incidents for a 'current month') may be adapted to suit the situation. This must be supported by an effective report logging and action monitoring procedure to ensure that issues are not missed, are kept under control and are seen through to resolution. Over time, longer-term statistics will emerge that, if the process has been enthusiastically kept up, should provide a useful leading indicator of safety on the site.
Appendix 3

Barriers to Near Miss reporting

Top 10 Barriers to Near-Miss Reporting

It’s a given that reporting of near misses reduces injury incidents. A report of a near miss (close call) creates an opportunity for identifying and removing hazardous conditions and work practices.

Then why is it so difficult to get your people to report near misses? Maybe they are discouraged by one of these common barriers:

1. They don’t know they are supposed to report near misses.
2. They don’t know how to go about it. They don’t know they should go to the supervisor.
3. They are afraid of being reprimanded or disciplined for actions that led to the incident.
4. They feel pressure from co-workers to keep quiet so nobody gets into trouble.
5. They are under pressure to maintain a clean incident record because the team will win a prize.
6. They are new and want to make a good impression.
7. The work culture says "suck it up and don't make a big deal out of it."
8. Co-workers are viewing the incident with humor instead of seeing the hazard. If everyone is laughing, how serious could it be?
9. Last time they tried to talk to the supervisor about something, they were belittled or disregarded.
10. It’s just too much trouble filling out those forms.
Appendix 3

Barriers to Near Miss reporting...

The top nine reasons why Workers don’t report Near Misses

1. Fear

Believe it or not, fear actually may be the least common reason workers avoid reporting near misses. It’s true that some workplaces cultivate an environment where employees are punished for being injured, so these workers are unlikely to report near misses if they fear they will lose their jobs. Overall, however, this usually isn't the most common reason workers neglect to report their near misses.

2. Embarrassment

If workers see their supervisors or co-workers humiliate those who make mistakes or experience incidents, they may be too embarrassed to come forward and admit they experienced a near miss.

3. Difficulty

If a Company makes near misses difficult to report, with confusing paperwork or a convoluted process, workers won't do it. Instead, supervisors should simply listen to the worker’s account of the near miss and then complete any necessary paperwork on the worker's behalf.

4. Bureaucracy

Some Companies may ask workers who experienced near misses to attend committees or meetings to share their stories. While this approach can work in some Companies, it also may be problematic. If workers suspect their near miss is going to trigger a bureaucratic machine of paperwork and meetings, they might rather avoid the whole thing.
The top nine reasons why Workers don’t report Near Misses....

5. Peer pressure

"This is the big one, if an injury or near miss cost the workplace its perfect safety record, which means all employees lost out on a cash bonus or prize, how will the employee reporting the Near Miss feel? Peer pressure from other co-workers can drive near misses underground.

6. Loss of reputation

Similarly, workers don’t want the reputation of being considered accident-prone or a cry-baby. "Macho" industries such as – construction or steel, etc. – may encourage a Culture where workers brag about their scars and never want to be seen as weak or unable to "take it." This can drive near miss reporting down, as well.

7. It’s easier not to

If workers suspect that no one at the Company actually cares about near-miss reporting, or think it will be too difficult or worry about being embarrassed, they may conclude that it’s simply easier not to report it. They might even think the near miss was not a big deal.

8. Lack of interest from the Company

When workers know the Company does not consider near misses important or take them seriously, they won’t, either. And if a Company does not actually use the near-miss information in a meaningful way, workers will be less inclined to report the near miss.

9. Perceived as pointless

If a near miss was not particularly serious and likely would not have resulted in a significant injury, some Companies may consider the process pointless. Companies cannot have it both ways – claiming that near-miss reporting is important but then complaining when “small” incidents are reported.
Appendix 4
Identification and analysis of Near Miss Incidents
Checklist

What behaviours or conditions can cause a Near Miss incident?
Examples include:

- Failure to maintain or repair equipment
- Removal of machine guards
- Failure to keep walkways free of slip, trip and fall hazards
- Inadequate training or personal protective equipment
- Not following procedures or poor procedure enforcement

No matter what the reason, if unsafe acts or conditions are identified and corrected, injuries most likely can be prevented

What other information would be important to preventing future accidents?
Examples include:

- Factors contributing to the incident (include unsafe acts and/or unsafe working conditions)
- Corrective actions necessary
- Responsibility for corrective action and date to be completed

In general, collect as much information as possible but remember the key point: The information must be effectively communicated throughout the Company to increase its value.
Appendix 4 (cont.)

Identification and analysis of Near Miss Incidents Checklist….

What tools, actions, attitudes or other things would make it easier to report and track your Near Miss incidents?

Examples include:

- The process assesses no blame
- Individuals and groups are not used as examples
- Forms are simple, reporting is easy
- Forms are readily available
- Positive recognition for those who report close calls
- Accountability for corrective actions

You cannot afford to ignore a Near Miss!

The concept is simple:
If Near Miss incidents are ignored, valuable safety lessons are lost.
If the causes of these incidents are not corrected, chances are good that an injury will result.

If corrective action is taken on all Near Misses, injuries may be prevented.
Report all Near Miss Incidents

It is a proposition you cannot afford to ignore

“Today’s Near Miss could be tomorrow’s fatality”
<table>
<thead>
<tr>
<th>Date</th>
<th>Report No.</th>
<th>Reported by</th>
<th>Dep't or Raising Report</th>
<th>Description of Report</th>
<th>Category</th>
<th>Near Miss or Observation</th>
<th>Action taken</th>
<th>Follow up</th>
<th>Closed off by/Date</th>
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</thead>
<tbody>
<tr>
<td>1.09.2013</td>
<td>1234</td>
<td>Mr Manager</td>
<td>B’ham</td>
<td>Plastic wrap loose on floor and frames for tube rack loose knocked over and left on floor</td>
<td>8</td>
<td>Near Miss</td>
<td>Mr Manager spoke to Joe Bloggs and has informed Mr Bloggs as to what he must do with unused straps</td>
<td>2.10.2013</td>
<td></td>
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<tr>
<td>25.09.2013</td>
<td>1235</td>
<td>Joe Bloggs</td>
<td>B’ham</td>
<td>Lack of fire signs in workshop</td>
<td>8</td>
<td>Observation</td>
<td>Joe Bloggs has spoken to Mr Manager</td>
<td>25.10.2013</td>
<td></td>
</tr>
<tr>
<td>10.10.2013</td>
<td>1236</td>
<td>Mr Manager</td>
<td>N. Yorkshire</td>
<td>Two coils pickled and oiled only 3 straps on each coil. All straps loose and twisted. Hooks not correctly secured to lashing points. Not strapped in accordance with ROR standards</td>
<td>1</td>
<td>Near Miss</td>
<td>Under Investigation</td>
<td></td>
<td></td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>No.</th>
<th>Issue</th>
<th>Code</th>
<th>Description</th>
<th>Category</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>LOAD SECURITY</td>
<td>2</td>
<td>PPE</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>TRAILER TIDINESS</td>
<td>5</td>
<td>TRAILER/VEHICLE DAMAGE</td>
<td>6</td>
</tr>
<tr>
<td>7</td>
<td>POTENTIAL INJURY</td>
<td>8</td>
<td>SITE</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>POTENTIAL HAZARD WITH CHEMICALS/FUEL</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>DANGEROUS/WITHOUT CARE DRIVING</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>12</td>
<td>REVERSING/BANKSMAN</td>
<td>13</td>
<td>TRAILER/CAB MAINTENANCE</td>
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<tr>
<td>15</td>
<td>INCIDENT WITH TRAIN</td>
<td>16</td>
<td>HAZARD CONCERNING BOAT</td>
<td>17</td>
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<tr>
<td>18</td>
<td>ILLEGAL PARKING</td>
<td>19</td>
<td>LOADING</td>
<td>20</td>
</tr>
</tbody>
</table>

- **POTENTIAL TRIP HAZARD**: 3
- **UNAUTHORISED PRESENCE/ACT**: 6
- **VEHICLE ALARM/DEFECT**: 10
- **GARAGE MISC**: 14
- **POTENTIAL DAMAGE TO LOAD**: 17
- **DROPPED TRAILER**: 20
“5 Whys” Investigation

ESTABLISHING UNDERLYING CAUSES - 5 WHYS?

Immediate Cause 1

WHY?

Organisation

Job

Because of Individual factors...........

WHY?

Organisation

Job

Because of Job factors.............

WHY?

Individual

Because of Organisational factors...........

WHY?