DEPARTMENT: **Construction Owners Association of Alberta**

SUBJECT: **Near-Miss Reporting**
Leading Indicator - Best Practice

1. PURPOSE

To communicate to COAA members a best practice for the implementation of a near miss reporting process that will identify opportunities to reduce risk exposure and improve EH&S systems structure.

1.1 SCOPE

To identify the benefits of having a good near miss process in place that will proactively improve the following EH&S processes:

- **Delegation of Safety Responsibility**: An effective near miss program shifts the task of identifying unsafe operations from Environmental, Health and Safety (EHS) management, to a much larger workforce that has intimate contact with process operations/equipment. By harnessing this larger workforce a greater number of safety related issues could be identified and addressed.

- **Increased Safety Awareness**: By making individuals more safety conscious and by shifting the responsibility of identification of near misses, unsafe conditions and behavior to each individual in the work force, both on and off the job safety of employees can be improved significantly.

- **Data Collection Pool:** The collection and analysis of near-miss data can reduce accident frequency through a) identification of similar incident precursors at other facilities, and b) pattern observation and trend analysis over time. Such a knowledge base would reduce risk exposure in on-going operations as well as future equipment, process and plant designs**.**

1.2 DEFINITION:

An event that under different circumstances would have resulted in loss to people, equipment, materials or the environmental.

The Wharton School report defined it as:

An opportunity to improve safety practices based on a condition or an incident with the potential for a more serious consequence.

STANDARD:

A successful near-miss process is achieved through carefully designed EH&S management systems with a positive organizational EH&S culture.

The seven steps to manage a successful near-miss process are:

A. Identification
B. Reporting
C. Communications
D. Cause Analysis
E. Corrective Action

F. Implementing Corrective Action
G. Follow-up

2.1 IDENTIFICATIONS:

Identification of a near miss is the first stage of the near miss process. In this stage having a clear definition and perception of a near miss event should be clearly commicated to all personnel. The definition should be anything that an employee views worthy to address to eliminate or reduce a potential to cause harm. The definition should include:

- Unsafe Conditions
- Unsafe Behavior
- Minor Incidents
- Property Damage
- Environmental Damage

2.2 REPORTING:

Management must create a culture where reporting of near misses is encouraged, and employees do not feel pressure not to report because of disciplinary action or peer pressure.

Completion of long forms will discourage reporting. Though the follow-up action may require a more detailed investigation, a simple near miss report and submission generally suffices for majority of near misses. If trying to find a near-miss report involves going to other areas, scrolling through web sites and not knowing who to report to will decrease reporting. Only one method for reporting may discourage employees from participating. Encourage employees to report a near miss any way they feel comfortable. Recognize employee thru incentive programs and remove the fear of disciplinary action.

2.3 COMMUNICATIONS:

Communicating information from near miss reporting remains a primary obstacle to the success of most near miss processes. To create a system to transfer near miss information to EH&S and employees to increase awareness of the condition or hazard the following must be ensured:

- Information must travel quickly.
- Information must reach all personnel.
- Information must be accurate and presented in a useful and understandable format.

2.4 CAUSE ANALYSIS:

When a near miss has occurred the next objective is to determine what action is required to ensure the near miss could not reoccur.
Two steps are required in determining the action to be taken:

1. Identify the causes / root cause
2. Identify solutions

In many instances an informal process between a supervisor and employee can determine actions taken. In cases where root cause is not apparent an investigation team may be required to determine the root cause and solutions.

2.5 CORRECTIVE ACTIONS:

It is imperative that a process be in place ensuring that all action items identified are followed until closure is in place to ensure employees see the benefits of reporting.

A system should be in place to promote action items that result from follow up to the near miss, this will ensure management accountability and provide feedback to employees. Posting and promoting near miss reports that are closed will ensure employees that action was taken.

2.6 IMPLEMENTING CORRECTIVE ACTIONS (MANAGEMENT RESPONSIBILITY):

Action items should be communicated to all employees to ensure that everyone has a through understanding of the recommendations. This would prevent miss interpretation or " Not viewed as important".

2.6 FOLLOW UP:

All near miss reports should be collected in a database. Often near misses are collected but rarely is the information communicated to address underlying safety issues.

3. INTERPRETATION AND UPDATING:

The Safety Chairperson of the Construction Owners Association of Alberta shall ensure interpretation and updating of their standard.

4. Approved By _____

Peter Dunfield
Chairperson
Construction Safety Association of Alberta