

# Reporting of and Learning from Hazards, Unsafe Behaviour and 'Near Miss' Incidents

## An overview and model procedure

### INTRODUCTION

Reporting and investigation of accidents that have occurred on a site is normally effective and efficient. Rather than simply applying such rigour to 'after-the-event' situations, where somebody has actually suffered injury, the ideal is for everybody on the site to be alert to potentially unsafe or unhealthy situations and for preventive 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 the unexpected sequence of events. Hence a missing guard, a slippery patch, a short-cut to procedure or a failure to use protective equipment can create a potential problem in the most rigorously assessed operation. The size and nature of a quarry site make such things especially difficult to control.

There is probably no perfect approach to monitoring this area, which relies upon subjective judgement and a constant willingness to act. However, if progress can be made in developing a culture wherein everyone on site is alert to risky situations, it has the potential to make the greatest contribution to good health and safety.

This guidance simply aims to promote thinking upon this subject and does not imply that any approach is 'ideal', although a simple approach is offered.

### OPPORTUNITIES

Attempts to promote this kind of awareness through procedures such as reporting cards have identified a number of difficulties. These can include:

- Unwillingness to implicate other people;
- Use of this kind of procedure to by-pass other reporting, e.g. delayed fitters' jobs;
- 'Tit for tat' reporting between groups;
- Focus upon contractors and visiting drivers, rather than in-house;
- Cultural resistance to taking 'management' responsibility for issues;
- Over-familiarity masking problems of poor conditions or procedure;
- An impression that this may be 'condescending' to experienced people;
- Difficulty in keeping up the momentum over time.

This should not be a discouragement, however, as even an imperfect process should highlight some issues and is better than leaving hazards ignored. Where a workforce does take increased ownership of the state of the site and safe procedure, this can have further benefit in encouraging good standards in other areas such as product quality and environmental control.

## REPORTING METHODS

Possibilities are:

- ◆ 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.

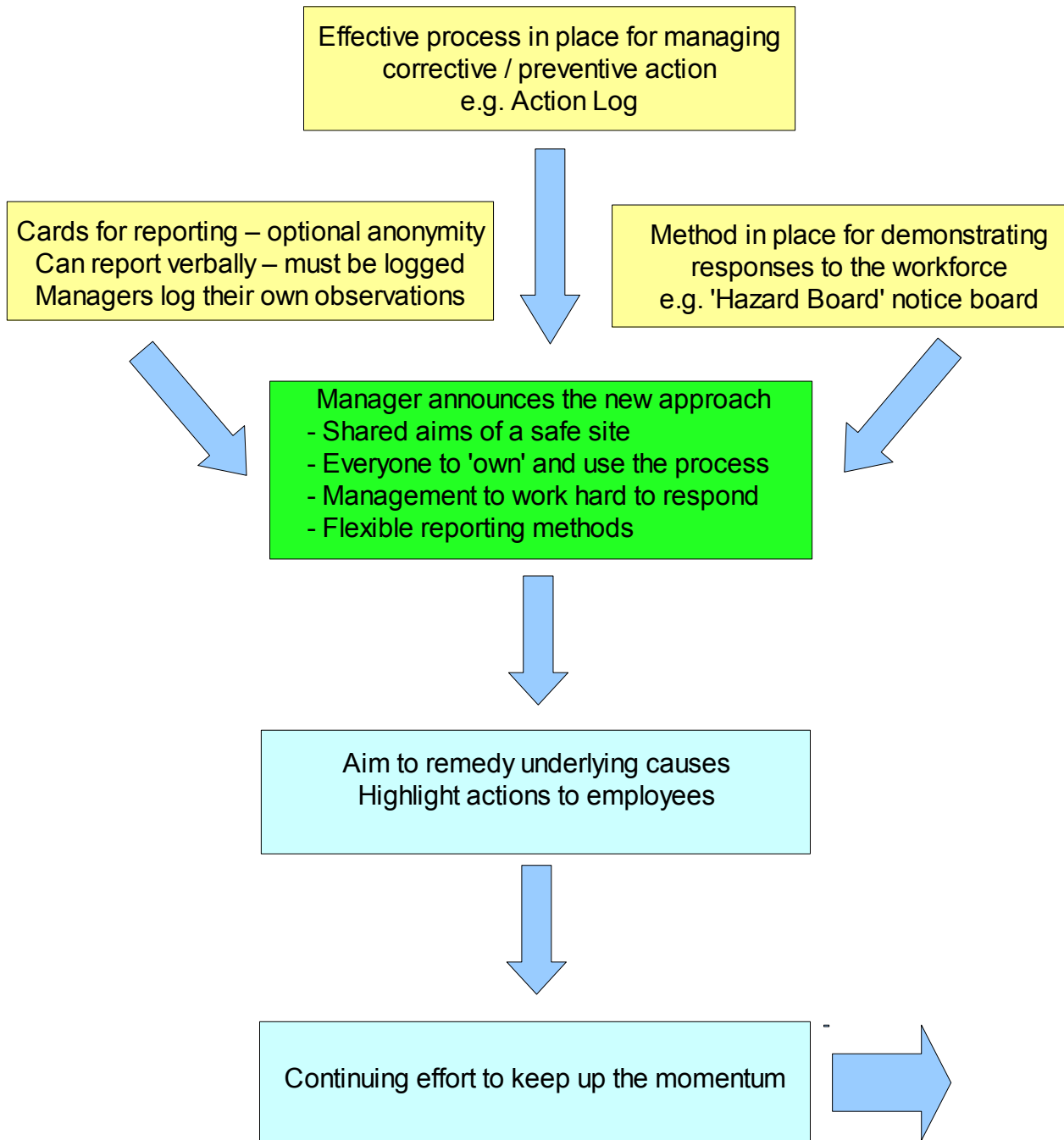
A further dynamic that cannot be ignored is that an unpleasant atmosphere may be created if people are giving reports naming individuals, whether signed or unsigned. While logically there is no excuse for an unsafe act or omission, the fact should not be ignored that team co-operation can be damaged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

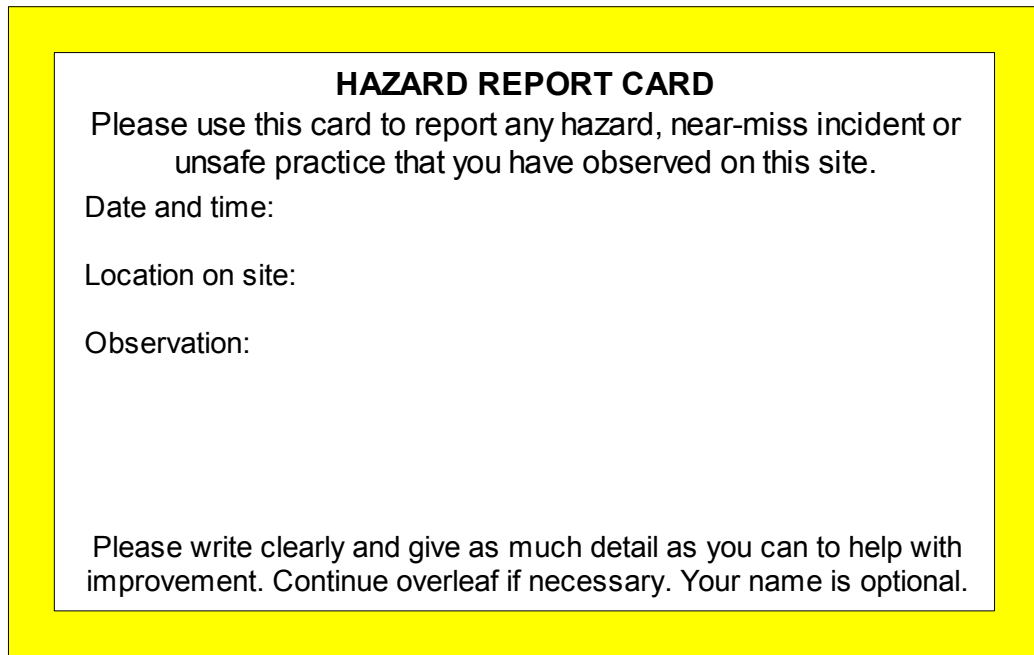
## A WAY FORWARD

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 are suggested as follows:

## INTRODUCING A HAZARD REPORTING PROCESS





**HAZARD REPORT CARD**

Please use this card to report any hazard, near-miss incident or unsafe practice that you have observed on this site.

Date and time:

Location on site:

Observation:

Please write clearly and give as much detail as you can to help with improvement. Continue overleaf if necessary. Your name is optional.

Figure 1. A possible simple 'Hazard Report Card' format

Figure 1 shows a possible format for a report card, which should be made easily available with 'postboxes' 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.

Figure 2 (below) 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.

<b>Hazard Board</b>		
Reports for period: <i>July 2006</i>		
Hazard Type	No of Reports	Action to Date
<i>Guard missing on conveyor 3</i>	<b>2</b>	<i>Priority fitter job ordered 05/07 - guard repaired and replaced 06/07 All fitters reminded of priority</i>
<i>No high vis -visiting driver</i>	<b>5</b>	<i>Spoken and written to manager of transport company 07/07 - <u>turn back drivers without PPE in future</u></i>
<i>Oil spill</i>	<b>1</b>	<i>Barrier and sign in place 17/07 . Clean-up ordered - Cleaned 18/07 Cause under investigation</i>
<i>Pipe fell from silo near driver</i>	<b>1</b>	<i>Refitted and tested immediately 20/07. Warning notice to be put up. All high structures to be checked</i>
<i>Seat belt not worn in quarry vehicle</i>	<b>2</b>	<i>Reminder issued to all personnel 20/07 - <u>this is a disciplinary offence</u></i>

Figure 2. A possible 'White Board' format for highlighting reports and actions

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.