Learning from Past Incidents Meeting Kit

LESSONS LEARNED

Many safety shares or incident investigations that are put out by a company to be reviewed at the field level may not deal directly with what work is occurring for a certain number of employees. That being said, no matter what hazard caused the injury or what the injury was that resulted, lessons can be learned from that incident and applied elsewhere. It is important to not put so much focus into the actual work task that caused the injury or what the injury was, but instead put more attention towards what applicable lessons can be applied to the work that you do.

Learning from accidents is the acquisition of knowledge and skills from a thorough study of accidents and their antecedents. The knowledge acquired may concern the types of unwanted events which may occur, the factors that can contribute to these unwanted events, the barriers which can prevent their occurrence, the possible consequences of the unwanted events, and the protective measures which can limit their consequences.

LEARN FROM CLOSE CALLS/NEAR MISSES

When a near miss/close call happens, it should immediately send up a red warning flag that something was wrong, unplanned, unexpected, and could happen again. The next time it happens, it could result in serious damage, injury, or death.

RECOGNIZE UNSAFE ACTS – EMPLOYEES ROLE

Most injuries are caused by unsafe acts, but most **employees** say they don’t commit unsafe acts. This discrepancy shows that more

attention needs to be placed on recognizing unsafe acts before an injury takes place.

- Being in a hurry or becoming angry tempts you to commit unsafe acts. Don’t succumb to temptation; stay focused on your safety commitment.
- Don’t let unsafe acts slip into your work routine.
- Take a moment to consider the safety of every action you take and avoid becoming complacent about the hazards of your work area.
- If unsafe conditions are discovered, correct or report the situation right away.
- Don’t allow a poor attitude to place other workers at risk.

- **Employees** need to understand that the purpose of studying near misses is not to punish employees or assign blame; it is to improve workplace safety and reduce injuries.
- Reporting close calls leads to improvements in work areas and job procedures while allowing the correction of unsafe conditions before an injury occurs.

MORE EMPLOYEE RESPONSIBILITY

Workers should inspect the work area daily for unsafe conditions or unsafe actions and, if found, report them to the supervisor. Take steps to eliminate hazards as soon as they are discovered. Learn the real lesson from close calls. They can happen again and again until they cause injury.

SAFETY MANAGEMENT PROGRAM

Near misses and resulting inspections may help prevent an injury or even a fatality, but an **investigation** cannot take place if the near miss is not reported accurately by employees. Setting up a successful **safety management program** is an important step in reducing occurrences of serious incidents.

The following steps will be incorporated in a successful program:

- Create a clear definition of a near miss.

- Make a written disclosure and report the identified near miss.
- Prioritize reports and classify information for future actions.
- Distribute information to the people involved in the near miss.
- Analyze the causes of the problem.
- Identify solutions to the problem.
- Disseminate the solutions to the people impacted.
- Resolve all actions and check any changes.

Avoid The Blame Game

Workers generally are not going to report a near miss/close calls if there is going to be a negative consequence for the report.

QUALITY OF INCIDENT INVESTIGATION

LFI is defined as “a process through which employees and the organisation as a whole seek to understand any negative safety events that have taken place to prevent similar future events.”

Conducting an incident investigation will provide deeper understanding of the associated risks in an organisation’s work activities. It is often observed that immediate and underlying causes of incidents have stipulated, instead of root causes in investigation reports, that indicating, having required expertise at initial stage of LFI process is critical as it is providing inputs into next stage of LFI process.

UNDERREPORTING OF INCIDENTS

No organisation can claim to be ‘highly reliable’ unless it demonstrates that a large number of incidents are reported, investigated, lessons learned and properly distributed, and effectiveness of actions have been evaluated.

POSITIVE SAFETY CULTURE, LFI PROCESS, AND EMPLOYEE INVOLVEMENT

Just as LFI is a human driven process, poor safety culture in organisations also leads to less reported incidents, poor quality investigation reports, less knowledge sharing, inefficient procedures and consequently ineffective learning process.

FINAL WORD

Time should be taken at the field level to discuss the incident as well as takeaways that are applicable to the work that is being completed that day. Think outside the box when discussing safety shares at work.