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SAFETY AND HEALTH TOPIC SHEET NO. 27: NEAR MISS AND UNDER REPORTING

A safety and health 'topic sheet' aimed at raising awareness of hazards in the rope access industry. The series may be of use as a toolbox talk.

1 INTRODUCTION …

1.1 A near-miss causes no immediate harm, but can precede events in which a loss or injury could occur.

1.2 Definitions vary. For example, the US National Safety Council defined a near-miss as:

"An unplanned event that did not result in injury, illness or damage – but had the potential to do so"

1.3 Members are encouraged to implement a robust near-miss reporting system as an opportunity to prevent future incidents, rather than waiting for losses to occur before taking steps to prevent them from occurring.

1.4 This requires worker consultation – and an understanding by all of why it is important.

2 IRATA – REPORTING REQUIREMENTS

2.1 Within IRATA, there is a requirement on members to report a 'dangerous occurrence'. This is defined as:

"Any event where no injury occurred, but which may have caused injury or death"

2.2 If an event did not have the potential to cause injury (or a fatality) it should not be reported as a dangerous occurrence.

2.3 NOTE: A decision not to commence work due to bad weather is not reportable as a dangerous occurrence; whereas the urgent need to abandon work due to unforeseen severe weather would, if injury might have occurred, be reportable.

2.4 In summary, there must have been no actual injury but there must have been potential for injury.

3 EXAMPLES OF SOME NEAR-MISSES

3.1 Examples of a range of reported near-misses include:

Case Study (1)
While changing bolts on a turbine nacelle, during a bolt tightening task, the removable head of the wrench and 13mm socket dropped into sea (within the exclusion zone). The tools were supplied by the customer. There was no method of secondary retention to the wrench handle of the removable head. Staff immediately stopped work and reported incident.

Case Study (2)

A rope access technician was installing insulation on the ejector using bands to hold the acoustic barrier in place. As they were cutting the banding with their snips, the knot on the banding tool came loose causing the tool to fall approximately 60 feet onto a mezzanine deck below.

Case Study (3)

A technician dropped a calibration test tool that was on a tool lanyard. The lanyard had snagged on their descent device. This resulted in the tool becoming detached. The tool should have been in a tool bag and not left hanging during the descent.

Case Study (4)

While walking to their lunch break, a technician stepped on a small chamber cover (30 cm by 30 cm and 20 cm deep) that was loose. They stepped through, with no injury. However, an injury might easily have resulted, e.g. strained or broken ankle.

Case Study (5)

A connector was dropped from the fifth floor landing onto a canopy below. The connector became disconnected from the tether during a changeover as the tether's loop slipped through the connector's opening, without the technician noticing.

Case Study (6)

While moving to another location on the worksite, a needle gun slipped from the technician's hand. It hit the steelwork and snapped, with the body of gun falling into the sea. The needle gun hose was attached to a 'cowstail'.

Case Study (7)

A technician was working on a mooring dolphin undertaking coating remediation. A crane barge was operating in the same location. The technician was repositioning using his descender, and descended below his hand ascender, until it was out of reach. If the sea conditions had of changed there would have been a potential situation where there could have been an interaction between the crane and the technician.

Case Study (8)

Glider clamps fell to sea. The clamp had been placed on top of a flat-topped tank. Whilst climbing off the tank the clamp snagged on the harness and, due to the lightness of the clamp and the gear carried on the harness, it wasn't possible to feel the clamp snagging. All attention was on foot placement to climb down on to the deck and the clamp movement wasn't noticed. There was a small gap between the tank and the walkway handrails and clamp fell to the sea.

4 IRATA – WORK AND SAFETY ANALYSIS (WASA) …

4.1 The statistics gathered using **Form 021** are used in the annual IRATA International 'Work and Safety Analysis' (WASA) to highlight the industry's safety record and opportunities for continual improvement.

4.2 The information is also used by IRATA's Health and Safety Committee (HSC) to determine whether there is a need to publish a Safety Bulletin and/or Topic Sheet.

5 WHAT IS THE PROBLEM …

5.1 Accidents and incidents can reoccur if nothing is done to change the circumstances and/or equipment that led to the event.

5.2 Within IRATA, there has been a view - for a number of years - that the number of dangerous occurrences reported does not reflect what is actually happening on site.

5.3 The recommendations in WASA include the following:

2011

"The increasing trend to report dangerous occurrences should be encouraged, particularly when relevant to rope access."

2012

"Reporting dangerous occurrences should continue to be encouraged, particularly when relevant to rope access and providing they meet criteria (no actual injury, real threat of injury or fatality)."

2013

"Reporting dangerous occurrences should be encouraged, particularly when relevant to rope access."

2014

"Members should be reminded of the requirement to report all accidents and incidents, however trivial."

2016

"Repeatedly, members should be reminded of the requirement to report all accidents, incidents and events with potential to cause injury or fatality."

2017

"The low level of reported events, particularly 'dangerous occurrences', in relation to the overall employment level and hours worked, continues to be of concern."

2018

"It is recommended that the IRATA … encourage the membership to report not only injuries, but all incidents that could have led to injury of fatality, i.e. 'dangerous occurrences'."

2019

"Several areas of improvements over previously reported accidents and incidents were observed, particularly significant was the reduction in instances of rope damage."

2020

"The substantial increase in reporting in 2019 by members should be acknowledged."

5.4 Incidents not reported may lead to damage to the reputation of the company involved and the wider rope access industry.

6 WHAT YOU CAN DO …

6.1 Members – and RACs – are encouraged to engage in a discussion about the importance of near miss reporting.

6.2 Learning from failure (things that have gone wrong in the past) is vital. We should be learning from the small events, as much as the big events.

6.3 Should they be required, three 'toolbox talks' are provided - see **Annex A, B and C** - to assist in any discussion on near miss reporting (and the apparent trend to under-report).

6.4 Members may wish to use their own resources.

"… If you see a risk that others take, that puts their health or life at stake. The question(s) asked, or thing(s) you say, could help them live another day …"

7 ACTION

7.1 Review your management system for near miss and under reporting (and start a dialogue with your technicians and managers).

8 REFERENCES

8.1 Further information can be found in:

(a) IRATA International code of practice for industrial rope access (Third edition, September 2016)[1]:

- Part 2, 2.11.12.2

  "In addition to any legal requirements, an accurate record of all accidents or near-misses should be kept, including measures to avoid a reoccurrence. All employees should be encouraged to report near-misses …"

- Part 2, 2.11.12.3

  "It is essential that the IRATA International work and safety statistics be completed for all hours worked on rope, accidents, incidents or near misses and returned promptly to IRATA International when requested …"

8.2 For a list of current (and past) 'safety communications' by IRATA, see www.irata.org

9 RECORD FORM

9.1 An example *Safety and Health Topic Sheet: Record Form* is given below. Members may have their own procedure(s) for recording briefings to technicians and others.

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1 https://irata.org/downloads/2055

10 FURTHER READING

IRATA Safety and health topic sheets:

- No. 2 Near misses: learning from failure
- No. 3 Avoiding dropped back-up devices
- No. 5 Safe rigging of rope access equipment
- No. 12 Hazard identification and risk assessment
- No. 22 Belief-based safety: attitudes and complacency
- No. 23 Accident and incident reporting

ANNEX A

1. Discuss

1.1 Discuss the following questions:

(a) Why should rope access technicians and/or IRATA member companies report accidents and near misses?

(b) Why don't rope access technicians report accidents and near misses (or member companies, for that matter)?

1.2 Document your responses – and then decide what you are going to do (as individual technicians and member companies).

2. Plan

2.1 Draw up an action plan and monitor it periodically.

3. Auditing

3.1 An IRATA Auditor may ask you about your plans for continuous improvement. This action plan will help but, more importantly, it will go some way to ensuring that you and your colleagues go home safely at the end of each day.

4. Supporting information

4.1 If leading a discussion, here are some responses provided by others:

(a) Why should people and/or companies report accidents and near misses?

- It is sometimes a legal requirement.
- To investigate serious incidents:
  - The data helps in undertaking a thorough investigation.
  - Hazards are addressed and how risks arise investigated.
- So that further advice can be provided.
- To provide an evidence-base for new legislation and/or guidance and/or procedures:
  - Review, including RAMS (Risk assessment and method statement).
- It is good practice to learn from accidents and incidents:
  - We learn from our mistakes.
- Prevention is better than cure:
  - Eliminate similar events from happening.
  - Ensures that risk is managed.
- Protect workers from harm.
  - They are protected and can go home safely.

- Accidents are detrimental to an organisation.
- Near-misses cause no immediate harm, but they often precede such events.
- The data provides a leading indicator (if collected and used properly).
- Putting something in writing means that there is a greater chance the issue will be resolved.

(b) Why don't people report accidents and near misses (or companies, for that matter)?

- They don't believe that what they witnessed is significant.
- It's not worth the time investigating it.
- They didn't think anyone would actually be injured.
- It's not a macho thing to do.
- The belief that IRATA might withdraw my membership
- They don't believe that the information will be treated confidentially.
- They feel very uneasy about speaking up
  - Don't like conflict
- They are too busy
  - Don't have the time
- They will get tied up in paperwork
  - Will then be under pressure to catch up
- It's not what we do round here
  - Don't really care
- The hazard may not have been identified
  - Lack of training
- Nothing will happen
  - It's all about speed and profit
- There is no commitment from management
  - Management doesn't care
- It's a blame game
  - I'll lose my job
- They feel intimidated

ANNEX B

1. Discuss

1.1 Discuss the following questions:

What could happen if incident reporting is:

(a) not done?

(b) not done well?

(c) not followed up?

(d) not recorded?

(e) followed up but outcomes are not communicated?

1.2 Document your responses – and then decide what you are going to do (as individual technicians and member companies).

2. Plan

2.1 Draw up an action plan and monitor it periodically.

3. Auditing

3.1 An IRATA Auditor may ask you about your plans for continuous improvement. This action plan will help but, most importantly, it will go some way to ensuring that you and your colleagues go home safely at the end of each day.

NOTE:
Risk assessment is a process. It is a means to an end (the elimination or mitigation of risk) and not the end itself (a piece of paper).

4. Supporting information

4.1 If leading a discussion, here are some responses provided by others:

What could happen if incident reporting is …

(a) … not done?

- The hazard(s) may not have been identified.
- Incorrect assumptions may be made about exposure to the hazard and any associated risks.
- Risk assessments may be flawed because the process has not included all the knowledge for the workplace or an activity.
- The outcome for the next technician may not be so favourable.

(b) … not done well?

- Risk assessments may not be 'suitable and sufficient'.
- Control measures may be ineffective because they are based on insufficient or incorrect information.

(c) … not followed up?

- If there is no remedial action, there remains exposure to the hazard.
- Technicians stop reporting because they think it is a waste of time when nothing happens.
- Equipment manufacturers will not be aware that there is a problem, so how will they know to recall or redesign their product(s)?

(d) … not recorded?

- Loss of on-the-job knowledge
- No opportunity to identify trends or clusters of incidents over time (i.e. lessons learnt can be lost).

(e) … followed up but outcomes are not communicated?

- Technicians may not know there have been changes in the safety system and that they need to modify their work practices
- A lack of positive reinforcement decreases the value of reporting.

ANNEX C

1. Discuss

1.1 Discuss the following question:

Most workplaces don't have an effective reporting culture for many reasons. Why don't technicians report near-misses?

1.2 Document your responses – and then decide what you are going to do (as individual technicians and member companies).

2. Plan

2.1 Draw up an action plan and monitor it periodically.

3. Auditing

3.1 An IRATA Auditor may ask you about your plans for continuous improvement. This action plan will help but, most importantly, it will go some way to ensuring that you and your colleagues go home safely at the end of each day.

4. Supporting information

4.1 If leading a discussion, here are some responses provided by others:

Most workplaces don't have an effective reporting culture for many reasons. Why don't workers report?

a). Technicians don't know that they should report things.

- Employer health and safety policies are unclear.
- Supervisors and technicians are not taught about their obligations.
- Technicians are told that it's not reportable.
- Workers may make a claim for an injury.

b). Technicians don't know how to report.

- Forms are not available.
- Technicians aren't trained or informed on the workplace health and safety policies and practices.

c). Technicians are afraid to report.

- The employer intimidates them from reporting hazards and/or coerces them into not claiming a benefit
- The employer blames workers for accidents instead of taking corrective action to solve the problem at the source.
- The employer claims economic hardships as a result of addressing safety concerns.

d). Technicians don't feel that there is any point in reporting.

- Management won't engage in worker consultation and involvement activities.
- Hazards are never addressed.

e). Technicians don't have time to do it.

- Teams are understaffed.
- Work assignments are overloaded.
- Shifts are not backfilled.
- Support is not available from supervisors.

IRATA SAFETY AND HEALTH TOPIC SHEET – RECORD FORM					
Site:					
Date:					
Topic(s) for discussion:			Topic Sheet No. 27: Near miss and under reporting		
Reason for talk:					
Start time:			**Finish time:**		
Attended by *Please sign to verify understanding of briefing*					
Print name:			**Signature:**		
Continue overleaf (where necessary)					
Matters raised by employees:			**Action taken as a result:**		
Continue overleaf (where necessary)					
Briefing leader *I confirm I have delivered this briefing and have questioned those attending on the topic discussed.*					
Print name:		**Signature:**		**Date:**	
Comments:					