CALIFORNIA GRAIN & FEED ASSOCIATION 2019

Understanding the importance of tracking near miss incidents

Presented by
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Know the difference!

ACCIDENT VS INCIDENT

WHAT IS AN ACCIDENT?

Any unplanned event resulting in:

- *Personal injury*
- *Illness*
- *Property damage*

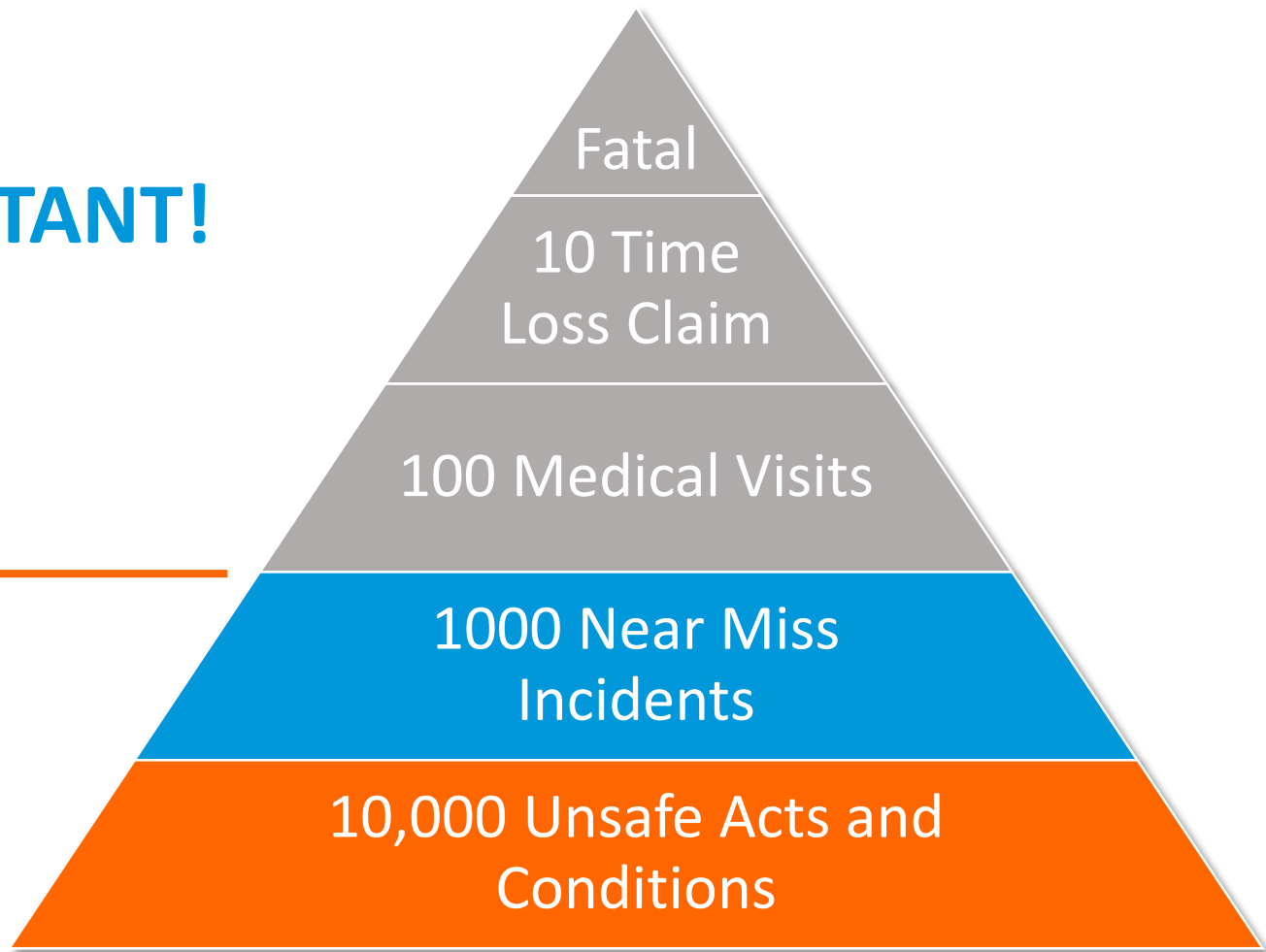## WHAT IS AN INCIDENT?

Any unplanned event **ALMOST** resulting in:

- *Personal injury*
- *Illness*
- *Property damage*

But had the POTENTIAL to result in any of those things
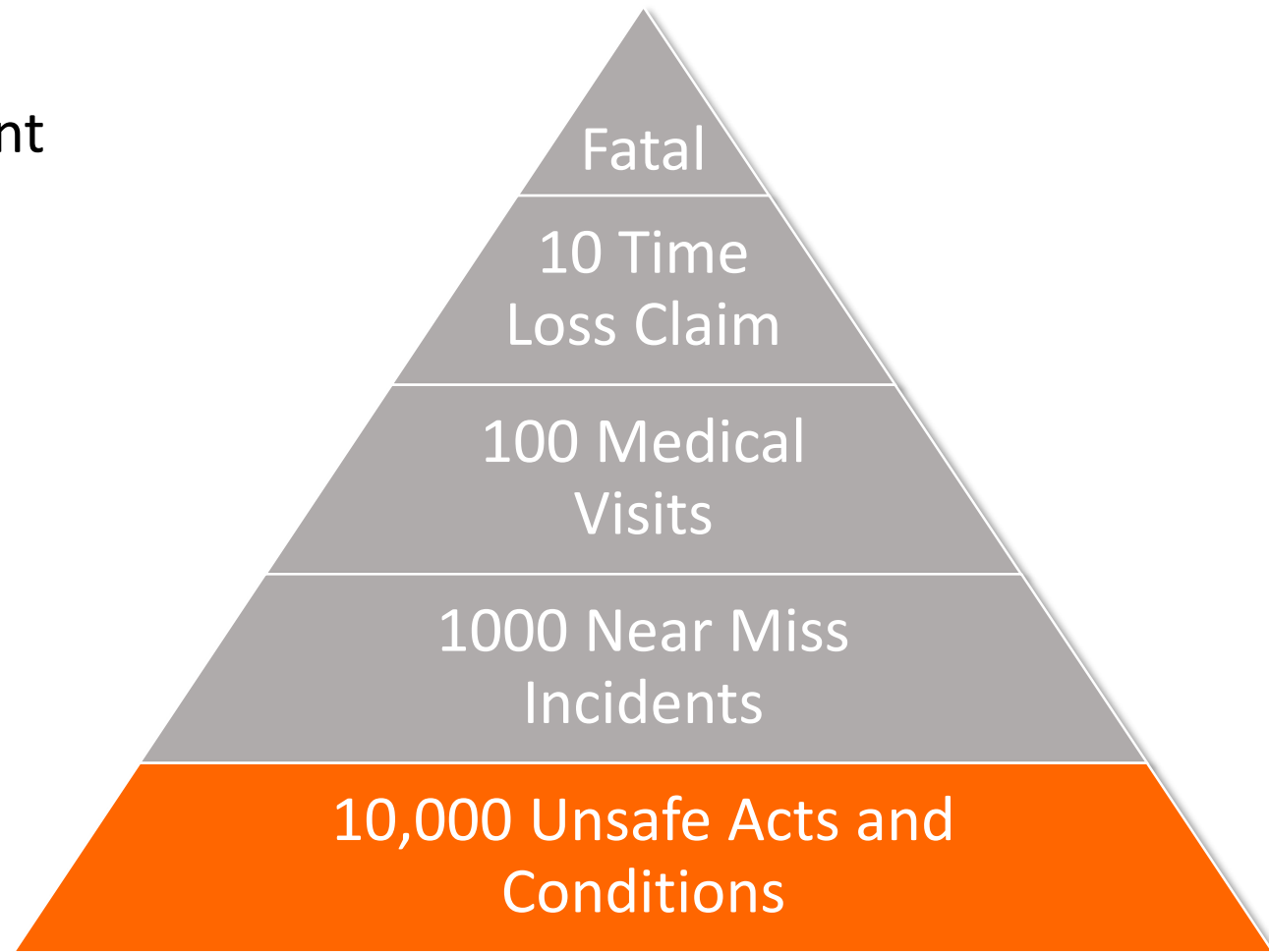
KNOWING EVERY INCIDENT IS IMPORTANT!

10,000 Opportunities!
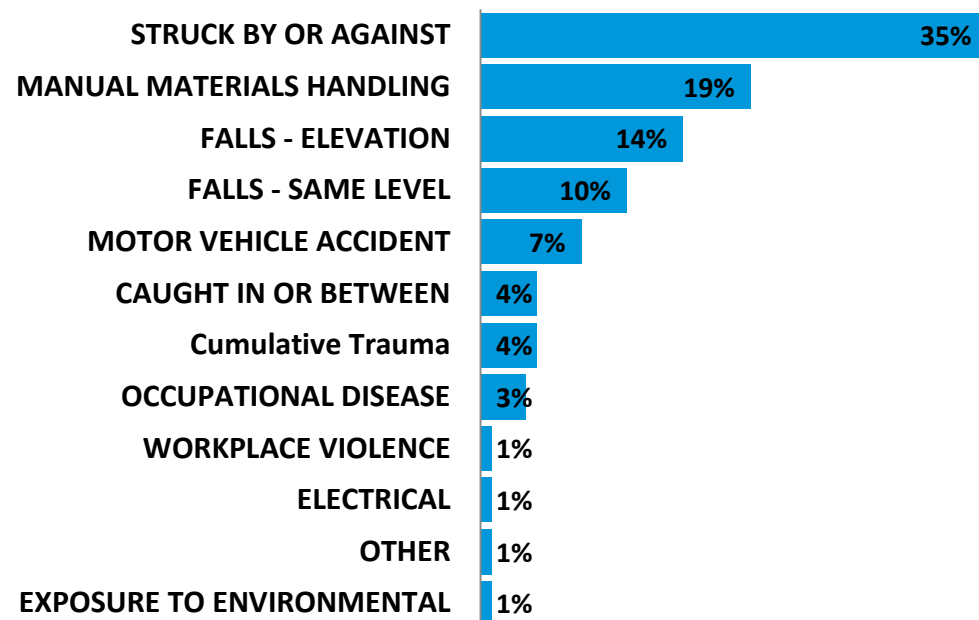
Your opportunity to prevent accidents!

Fatal

10 Time Loss Claim

100 Medical Visits

1000 Near Miss Incidents

10,000 Unsafe Acts and Conditions

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- Defective safety equipment
- Ineffective maintenance
- Missing safety devices
- Unrecognized hazards
- Insufficient warnings
- Inadequate training
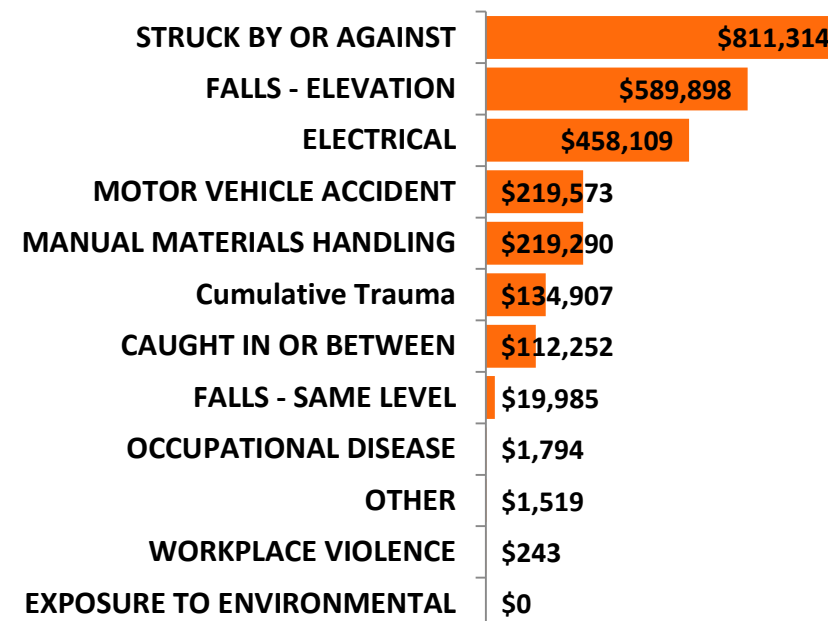- Poor housekeeping
- Deficient signage
- Lack of caring

Fatal

10 Time Loss Claim

100 Medical Visits

1000 Near Miss Incidents

10,000 Unsafe Acts and Conditions

INDUSTRY BENCHMARKING DATA

Risk Exposure Type - Frequency

Risk Exposure Type	Frequency
STRUCK BY OR AGAINST	35%
MANUAL MATERIALS HANDLING	19%
FALLS - ELEVATION	14%
FALLS - SAME LEVEL	10%
MOTOR VEHICLE ACCIDENT	7%
CAUGHT IN OR BETWEEN	4%
Cumulative Trauma	4%
OCCUPATIONAL DISEASE	3%
WORKPLACE VIOLENCE	1%
ELECTRICAL	1%
OTHER	1%
EXPOSURE TO ENVIRONMENTAL	1%

Risk Exposure Type – Costs (Severity)

Risk Exposure Type	Cost
STRUCK BY OR AGAINST	$811,314
FALLS - ELEVATION	$589,898
ELECTRICAL	$458,109
MOTOR VEHICLE ACCIDENT	$219,573
MANUAL MATERIALS HANDLING	$219,290
Cumulative Trauma	$134,907
CAUGHT IN OR BETWEEN	$112,252
FALLS - SAME LEVEL	$19,985
OCCUPATIONAL DISEASE	$1,794
OTHER	$1,519
WORKPLACE VIOLENCE	$243
EXPOSURE TO ENVIRONMENTAL	$0

Based on a loss analysis of 136 accidents over 5 year period 2013-2018

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Agent (Cause) - Frequency

Vehicle	21%
Hay	12%
Feed sack/bag	12%
Slip/Fall Noc	9%
Noc	8%
Foreign body in eye,…	4%
Nail	4%
Ladder	4%
Tarping	3%
Trailer	3%
Grinder	3%
Feeder bowl	3%
Rail car	3%
Step	3%
Pallet	3%
Metal object	3%
Truck/Trailer	3%
Rail cart	3%

Agent (Cause) – Costs (Severity)

Vehicle	$835,691
Electric	$458,109
Hatch door	$417,069
Bobcat	$117,075
Noc	$108,628
Truck scale	$104,527
Feed sack/bag	$84,397
Fan blad	$78,272
Tarping	$49,699
Product Noc	$40,278
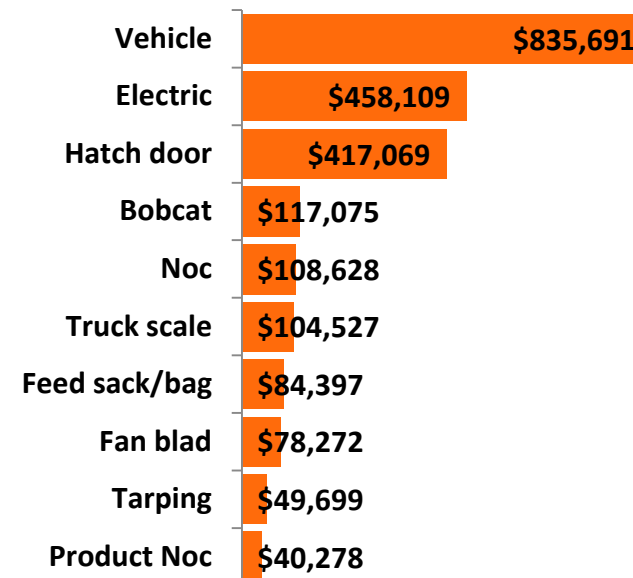
Based on a loss analysis of 136 accidents over 5 year period 2013-2018

INDUSTRY BENCHMARKING DATA

MAJOR LOSS SOURCE SUMMARY

Row Labels	Number of Accidents	% of accidents to total	Sum of Incurred Costs	% of Total Incurred
STRUCK BY OR AGAINST	45	35%	$811,314	32%
MANUAL MATERIALS HANDLING	24	19%	$219,290	9%
FALLS - ELEVATION	18	14%	$589,898	23%
FALLS - SAME LEVEL	13	10%	$19,985	1%
MOTOR VEHICLE ACCIDENT	9	7%	$219,573	9%
CAUGHT IN OR BETWEEN	5	4%	$112,252	4%
Cumulative Trauma	5	4%	$134,907	5%
OCCUPATIONAL DISEASE	4	3%	$1,794	0%
WORKPLACE VIOLENCE	1	1%	$243	0%
ELECTRICAL	1	1%	$458,109	18%
OTHER	1	1%	$1,519	0%
EXPOSURE TO ENVIRONMENTAL	1	1%	$0	0%
Grand Total	**127**	**100.00%**	**$2,568,882**	**100.00%**

Short round table discussion(s) re: accidents or nm they've encountered, each group offer their most unusual or most relevant to the group as a whole.

Distribute accident summary handout

10 minutes

End
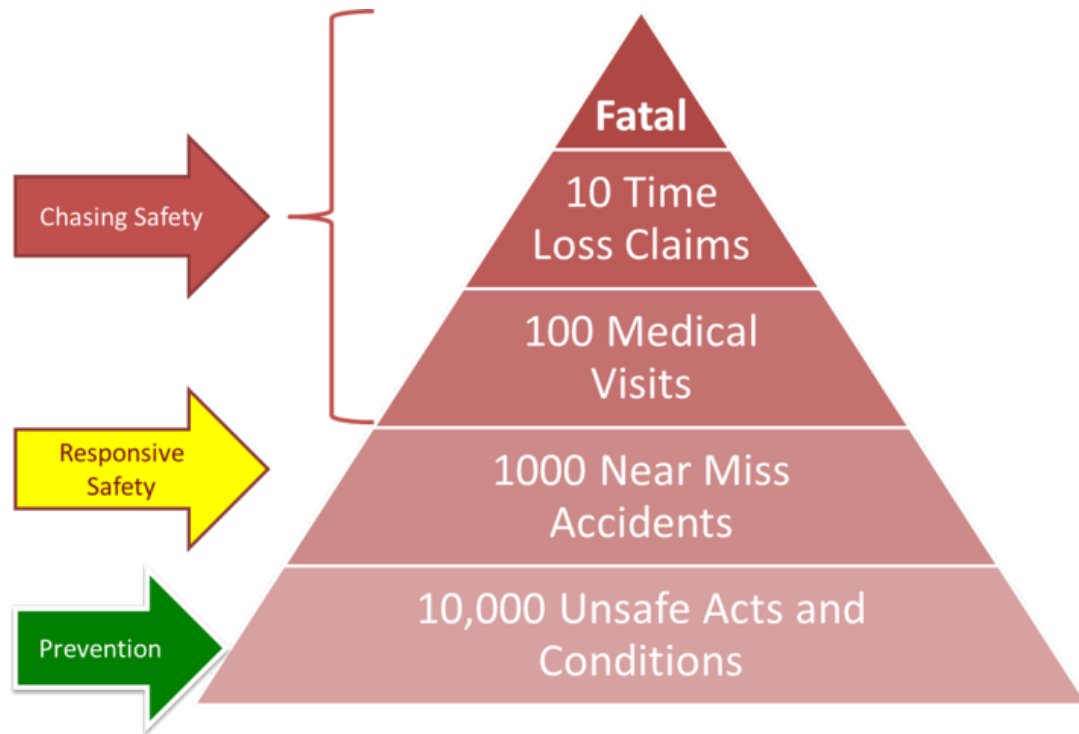
- Check the effectiveness of training programs
- Promote on-the-spot correction of unsafe acts
- Provide opportunities to compliment and/or reward safe behaviors
- Develop cooperative safety attitudes
- Promote more learning about the employees in your department
- Suggest and identify better job methods, increasing production and making the Supervisors' job easier

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01

OBSERVING

WHAT IS A SAFETY OBSERVATION

- Some are unintentional
- Some are intentional
  - *Part of routine hazard assessments*
- Some are of people, behaviors and actions
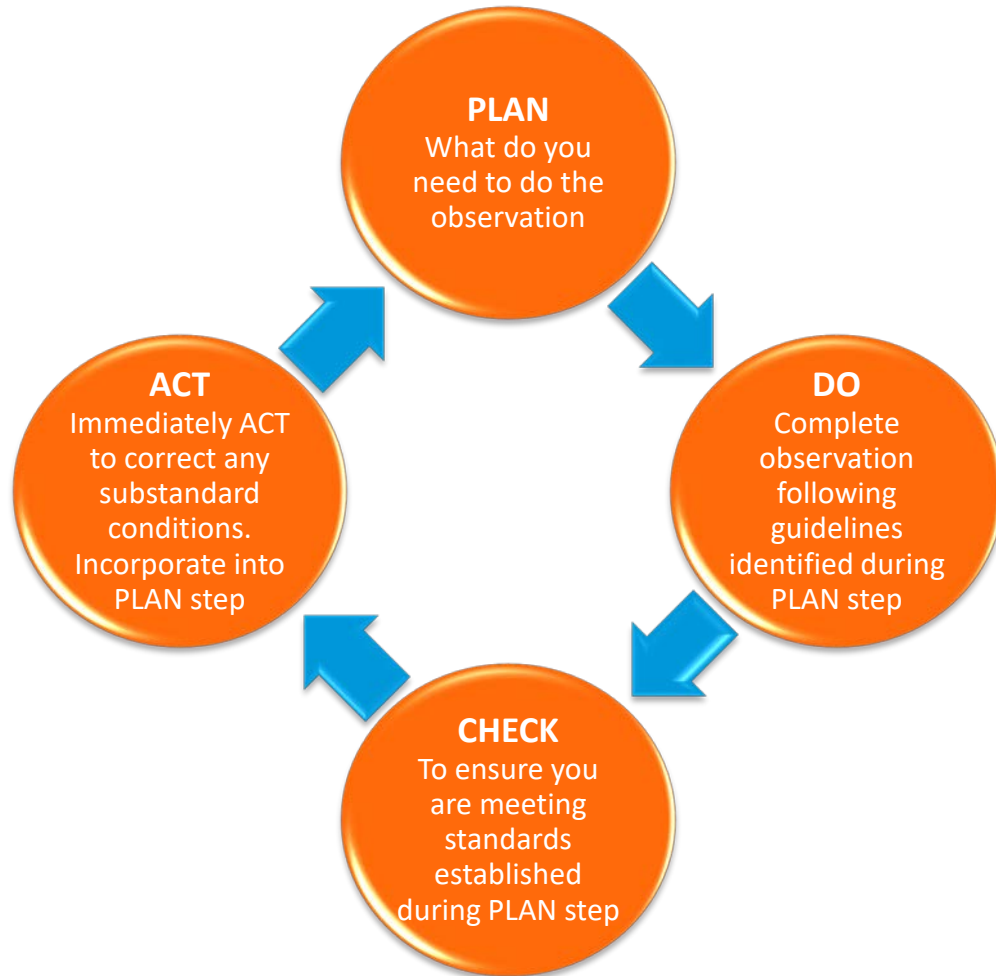- Some of are objects and processes
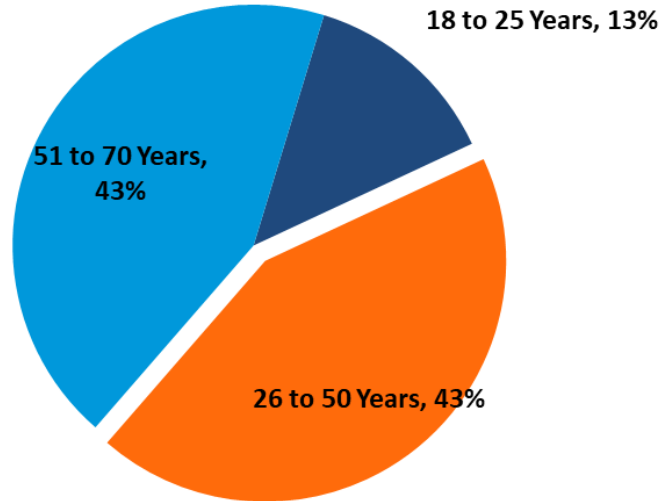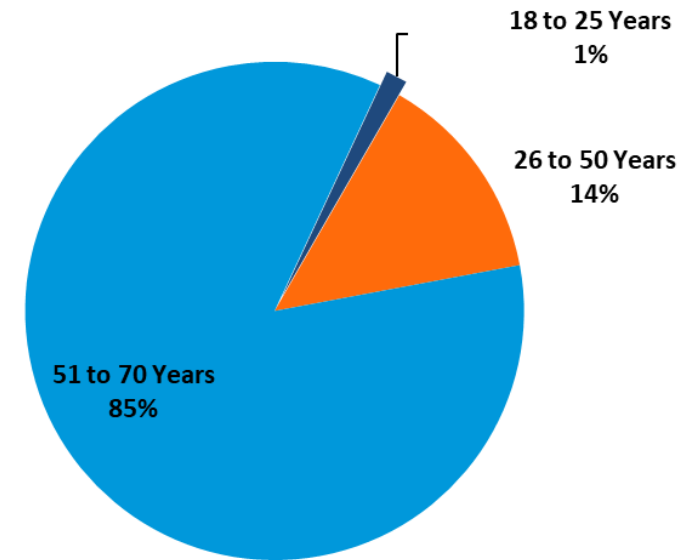
- Traditional safety efforts focus on the conditions
- 90% plus of all accidents have an critical behavior cause
- Most accidents have multiple causes
  - Behavior
  - Condition
  - Organizational
- Required under your IIPP Element "Hazard ID and Correction"

10%
95%
60%

- Organizational Causes
- Unsafe Act Causes
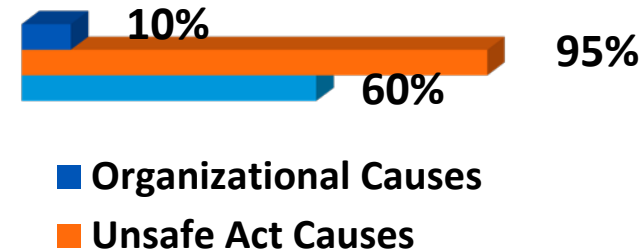
- **Incidental Observations**
  - Part of other work activities
  - Short observations and feedback sessions

- **Deliberate Observations**
  - More planning and foresight
  - Separate time is set aside to perform the deliberate observation

- **Who should be Observed**
  - ICWG Benchmark data shows that employees with **6 mo. - 1 year tenure has 21%** of accidents, those with **10-20 years have 63%** of accidents
  - "Problem" people
  - EE's working out of normal scope

- **Frequency for Observations**
  - New hire - 3 in first month
  - Existing employee - 1 per month
  - New process
  - Post accident/incident or other observation

*Feedback should always be provided using the **Behavior Impact Tomorrow** format*

PLAN
What do you need to do the observation

DO
Complete observation following guidelines identified during PLAN step

CHECK
To ensure you are meeting standards established during PLAN step

ACT
Immediately ACT to correct any substandard conditions. Incorporate into PLAN step

- Identify who, what, where needs an observation
- Decide what you are looking for including job steps, hazards, and proper controls
- Look at a scheduling of tasks in the workday and ensure observation coincides to task
- Decide if you should tell the employee or group prior to the observation

02
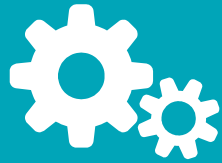
CORRECTING

DIGGING INTO THE "W'S" (NOT THE "H")

- **WHO?**
- **WHAT?**
- **WHEN?**
- **WHERE?**
- **WHY?**

Not enough to just ask "**HOW DID THIS HAPPEN?!**"

Must also ask, "**WHY DID THIS HAPPEN?!**"

And keep asking **WHY** until you discover the root cause(s).

DIRECT CAUSE:

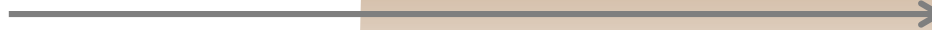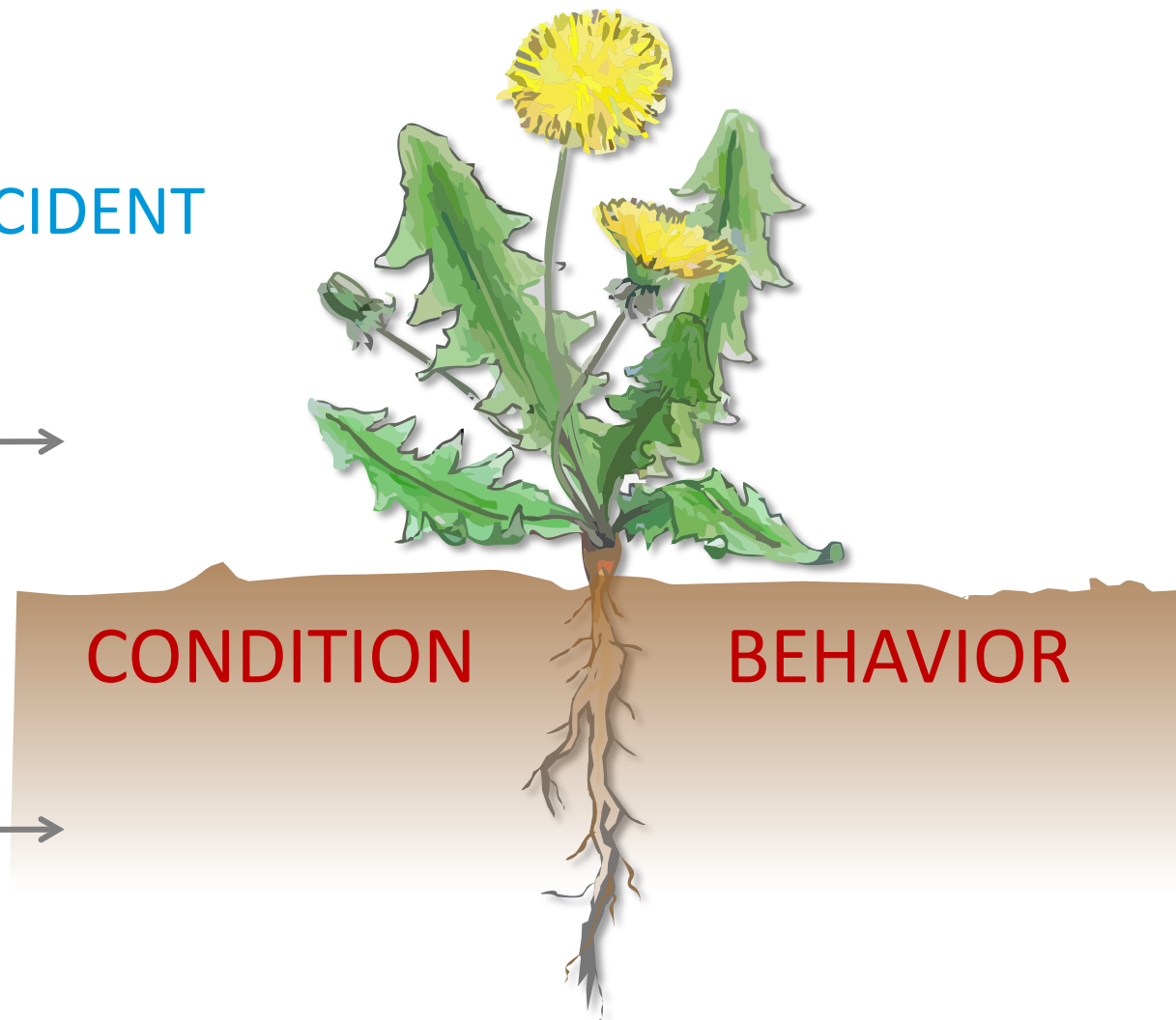WHAT DIRECTLY CAUSED THE INCIDENT

Worker (almost) cut off finger

HOW????

- Not using a push block for table saw
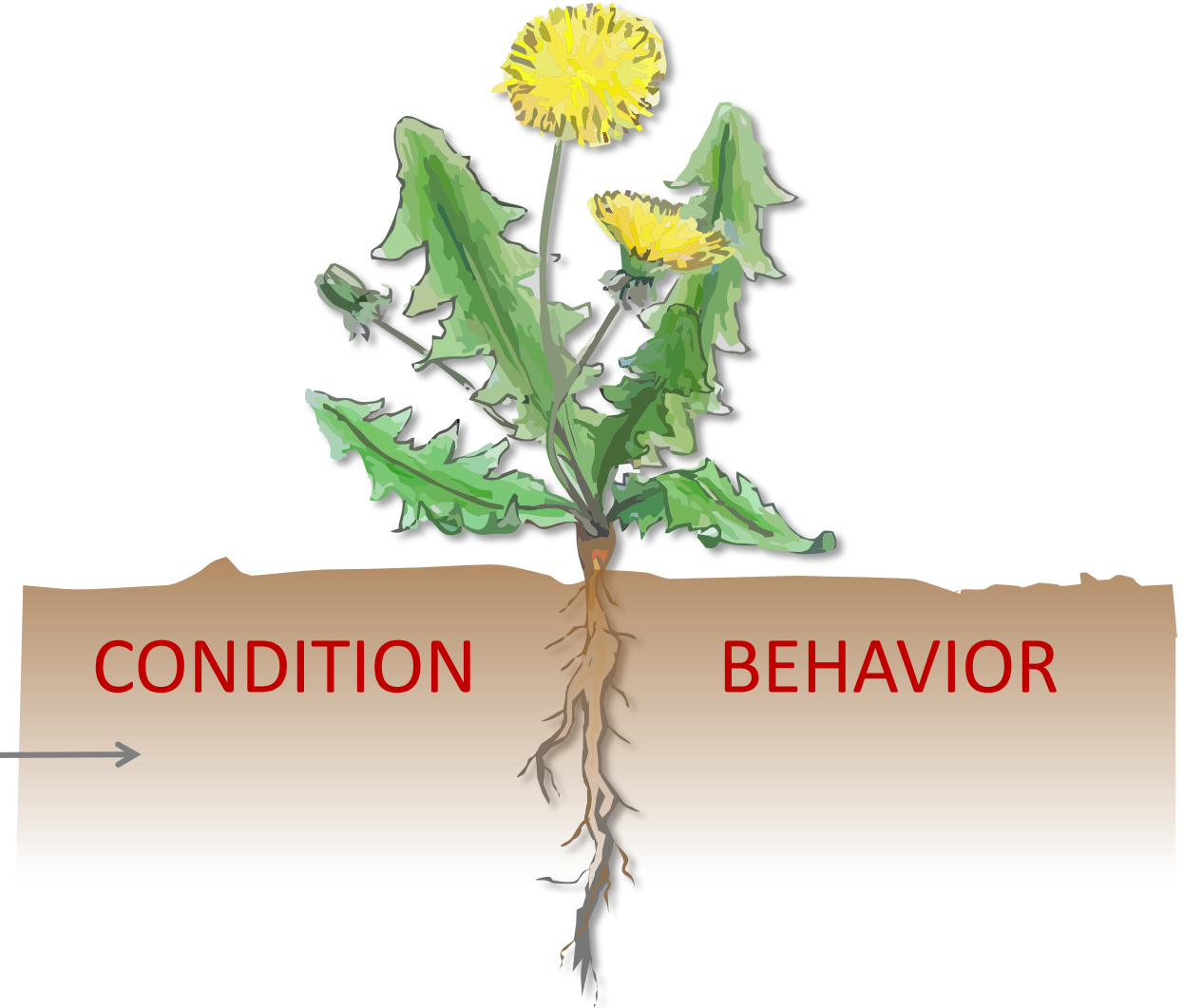- Not using guard(s)
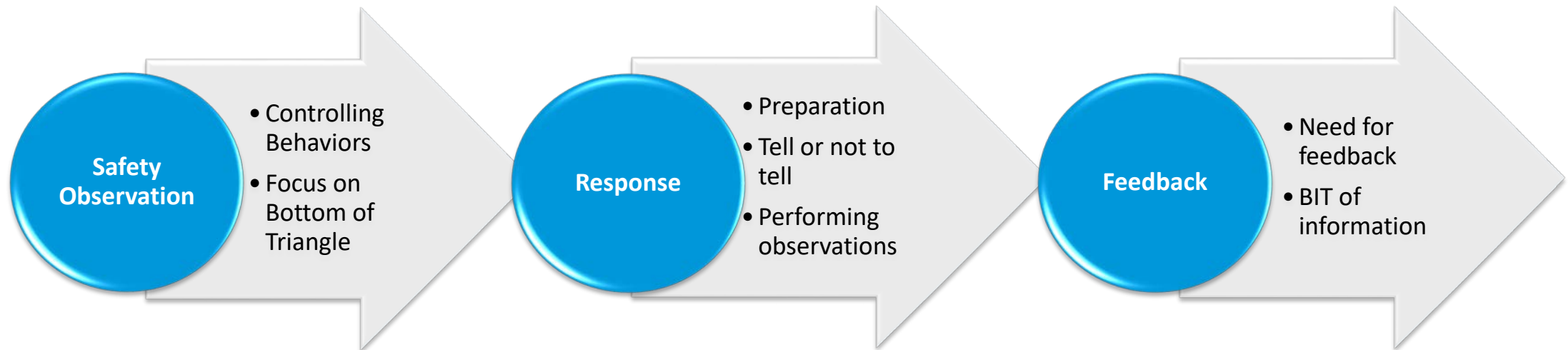
WHY????

CONDITION   BEHAVIOR

ROOT CAUSE:

WHY THE INCIDENT OR ACCIDENT OCCURRED

- Company doesn't own a push block: **WHY?**
- Guards not available? **WHY?**
- Employee not properly trained: **WHY?**
- Employees not encouraged to observe & report: **WHY?**
- General culture is to use regardless of lack of safety devices? **WHY?**

CONDITION   BEHAVIOR

Safety Observation
- Controlling Behaviors
- Focus on Bottom of Triangle

Response
- Preparation
- Tell or not to tell
- Performing observations

Feedback
- Need for feedback
- BIT of information

- Evaluate whether the employee knows how to do the job

- Complete an informed safety observation

- Evaluate how the employee performs their work (do not inform them prior to completing the observation)
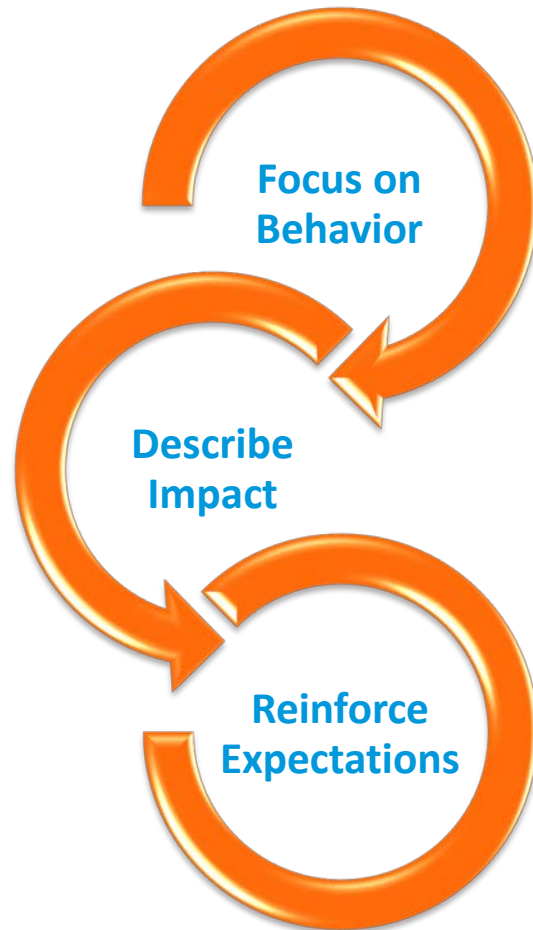
- In all cases – always provide feedback

When unsafe behaviors are observed, employees must be coached in the correct method

- Tell them how to do the job

- Show them how to do the job

- Have them demonstrate correct way

- Make corrections or reinforce with a compliment

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Focus on Behavior

Describe Impact

Reinforce Expectations

Tell the employee that you completed a safety observation

- **B**ehavior – Make sure employee understands the positive or negative behavior that was observed

- **I**mpact – Link the impact to a personal level, unit level, plant level and corporate level

- **T**omorrow – What action's do you expect the employee to complete tomorrow and on

03
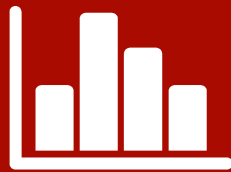
REPORTING

- ## What to report
  - Consider having a formal program, statement or outline
- ## How to report
  - Form vs. verbal
- ## Who should report
  - All employees should have an opportunity
  - Outline the process in your Program
- ## What to track
  - Facility/Department, Supervisor, Employee, Equipment, Activity or Agent…
- ## How to track

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C:\Users\rskinner\Desktop\NEAR MISS INCIDENT PROGRAM.docx

C:\Users\rskinner\Desktop\NEAR MISS INCIDENT REPORT.docx

REPORTING SAMPLE LOG

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	B	C	D	E	F	G	H	I	J	K	L	M
1				Near Miss Accident/Incident Log						Near Miss Accident/Incident RC Analysis		
2												
3	Location (Facility/Dept)	Employee	Supervisor	Brief Statement/Description	Equipment	Activity or Agent	Major Loss Source	Unsafe Behavior/Act	Unsafe Condition	Incidental Causes/ Contributing Factors	Root Cause(s)	Corrective Action
4												
5												
6												
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21												

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- Evaluate incident & injury trends to focus safety/risk management efforts
- Use 300 forms, incident logs & reports, inspection reports, etc.
- Use Excel tools analyze
  - Sort functions
  - Pivot tables
- Determine how frequently to review in your Program

REPORTING SAMPLE LOG

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- Identify trends within each heading/category
- Evaluate/rate trends to determine priorities
- Create & implement a mitigation plan
  - *May need to do a root cause analysis first*
- Employee engagement
  - *Discuss incident prevention*
  - *Solicit employee ideas, involve them in soultions*

- Did mitigation work?

- What is outcome?

- More problems?

- Solved?

- Continuously monitor
  (MORE – Observing, monitoring, etc.)