A Rules-based System to Support Effective Incident and Near-Miss Management Programs

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### **Outline**



- What is a Near-Miss?
  - Notable Examples Near-Misses Ignored
  - The Safety Pyramid
- Benefits of Incident Tracking and Near-Miss Programs
- Opportunities for Improvement
- Tr@ction<sup>™</sup> An Example of Automated Best Practices In Action





... an opportunity to improve environmental, safety, and health practice based on a condition, or an incident with potential for more serious consequence.











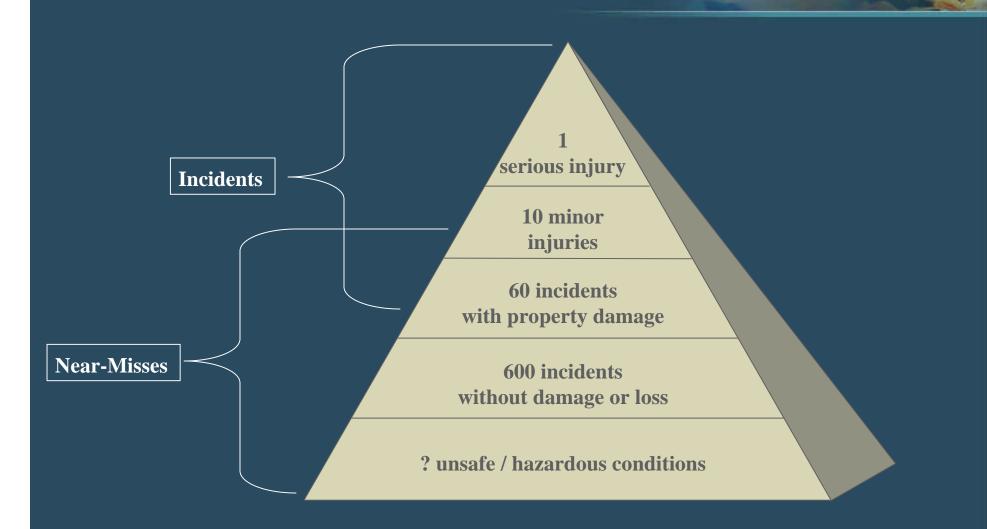
- Unaddressed or un-remedied unsafe conditions can lead to significant OHSA penalties.
- Sound management of risk depends on accurate information about state of follow up actions in an organization.
- Public scrutiny of hazardous facilities increasing with consequences for bottom line results.

## Notable Examples of Near-Misses Ignored

- 1986 Space Shuttle Challenger Explosion (US)
- 1997 Hindustan Refinery Explosion (India)
- 1999 Paddington Rail Crash (UK)
- 1998 MortonExplosion and Fire (US)



### **The Safety Pyramid**







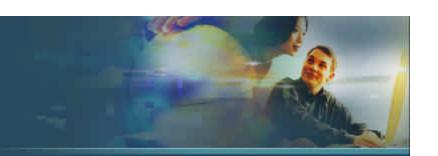
Identify weaknesses in safety management systems through accident precursors.











- Delegation of Safety Responsibility
  - Harnessing the larger workforce to identify unsafe operations.
- Increased Safety Awareness
  - Making individuals more safety-conscious.
- Creation of an Information Pool
  - Creating a knowledge base to reduce risk exposure.

# Elements of a Near-Miss and Incident Tracking Management System



Identification Reporting

Disclosure

Distribution Dissemination Causal Factors Analysis Solution Identification

Resolution

- Identification/Reporting incident recognized/reported.
- Disclosure individual / group reports incident, case file opened.
- Distribution/Dissemination information transferred for follow-up. Rules-driven workflow.
- Causal Factors Analysis direct / root causes identified.
- Solution Identification find solution to each causal factor.
- Resolution complete follow-up, close out, summarize and report.

Modified from Near Miss System Analysis: Phase I, December 2000, Phimister, Oktem, Kleindorfer, and Kunreuther, Wharton School Center for Risk Management and Decision Processes, University of Pennsylvania

## Identification/Reporting – Best Practices



Identification Reporting

Disclosure

Distribution Dissemination Causal Factors Analysis Solution Identification

- 37% of the respondents felt this was an area for significant improvement.
- Adopt broadly-encompassing definition of what constitutes a near-miss or incident.
- Automate identification of near-misses.
- Automate reporting of incidents.
- It is estimated that 1/3 of sites do not have effective systems to aid in identification of nearmisses.

## Identification/Reporting – Best Practices



Identification Reporting

Disclosure

Distribution Dissemination

Causal Factors Analysis Solution Identification

- Examples of near-misses under this definition:
  - Unsafe conditions.
  - Unsafe behavior.
  - Minor accident/injuries that had the potential to be more serious.
  - Events where injury could have occurred but did not.
  - Events where property damage resulted.
  - Events where a safety barrier was challenged.
  - Events where potential environmental damage could result.





Identification Reporting

Disclosure

Distribution Dissemination

Causal Factors Analysis Solution Identification

- Make report forms simple and readily available
- Encourage reporting
- Provide incentives for reporting
- Share near-miss reports widely
- 26% of the respondents felt this was an area for significant improvement

## Distribution/Dissemination - Best Practices



Identification Reporting

Disclosure

Distribution
Dissemination

Causal Factors Analysis Solution Identification

- Provide clear guidelines
- Empower employees and supervisors
- Provide electronic platforms
- Automate dissemination
- Initiate action tracking
- Disseminate to a broad audience
- 58% of the respondents felt this was an area for significant improvement

## **Causal Factors Analysis – Best Practices**



Identification Reporting

Disclosure

Distribution Dissemination

Causal Factors Analysis Solution Identification

- Train supervisors in methods of causal factor analysis
- Capture direct causes and root causes

## **Solution Identification – Best Practices**



Identification Reporting

Disclosure

Distribution Dissemination

Causal Factors Analysis Solution Identification

- Link solution identification to causal factors
- Develop at least one solution or corrective action for each causal factor
- Link to work order system
- Address Management of Change issues





Identification Reporting

Disclosure

Distribution Dissemination Causal Factors Analysis Solution Identification

- Automate action tracking
- Integrate with work order system
- Integrate with HR systems
- Provide feedback to reporter when corrective actions are completed
- 53% of the respondents felt this was an area for significant improvement





An integrated incident reporting and action tracking system to allow manufacturing organizations to:

- Monitor and analyze trends and identify areas for improvement.
- Analyze safety performance across business units.
- Identify areas for pro-active loss prevention/reduction.
- Track actions associated with EHS incidents, safety audits, general EHS audits and, Hazop Reviews.

## Tr@ction Was Developed Because Market Products Failed to Meet BP HSSEQ Management and Visionary Needs



As an acknowledged leader in HSSEQ management, BP knew what features were required for a successful tool...

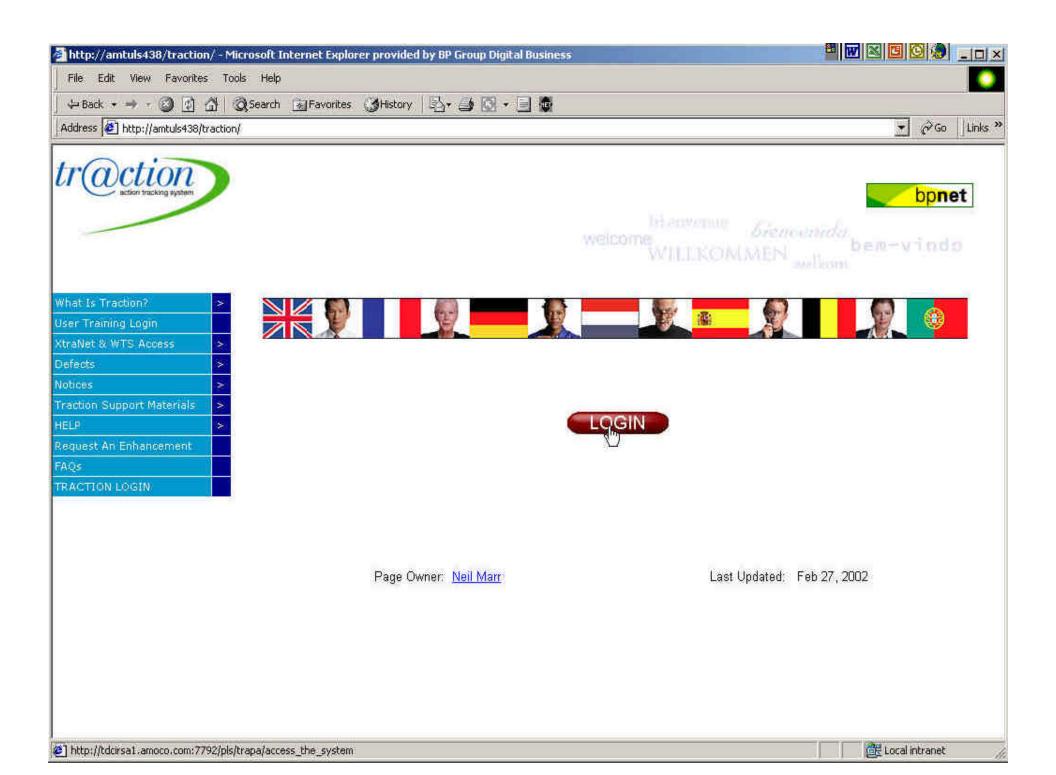
- Global application / multilingual access
- Ease of use / local configuration
- Progress on actions transparency
- Delivery of regulatory requirements worldwide
- Data protection / data migration
- Simple flexible reporting

# Tr@ction Was Developed Because Market Products Failed to Meet BP HSSEQ Management and Visionary Needs

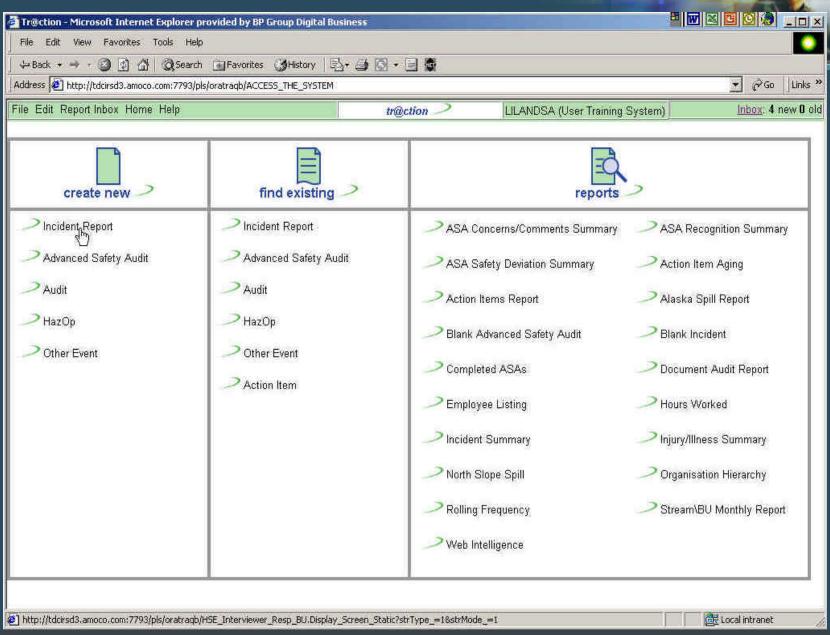
As an acknowledged leader in HSSEQ management, BP knew what features were required for a successful tool...

- Universal Access
- Unplanned Events (Major to Minor/Cradle to Grave)
- Electronic Management / Efficient Operations
- Management of Organizational Change
- Modularity / Beyond HSSEQ
- Consistent Data

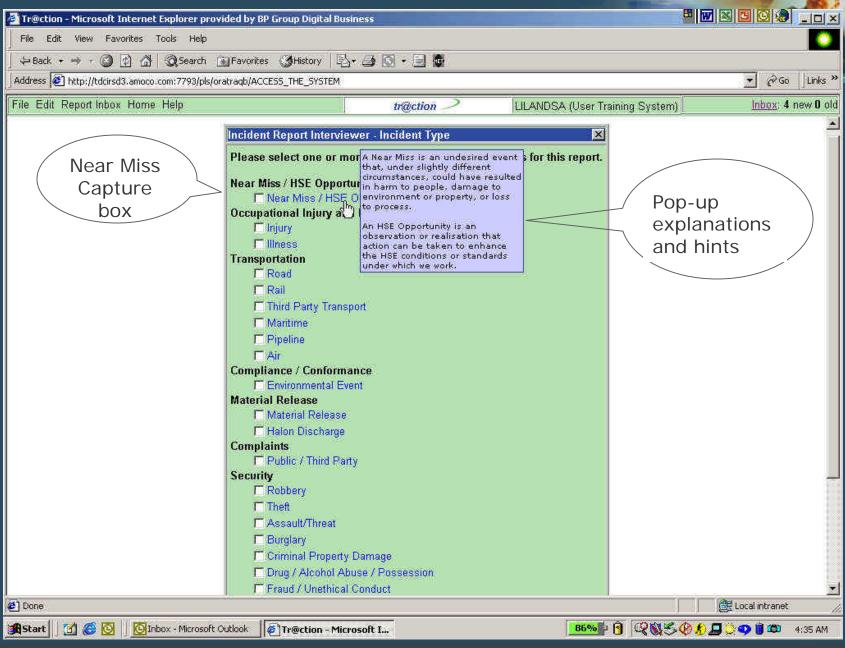


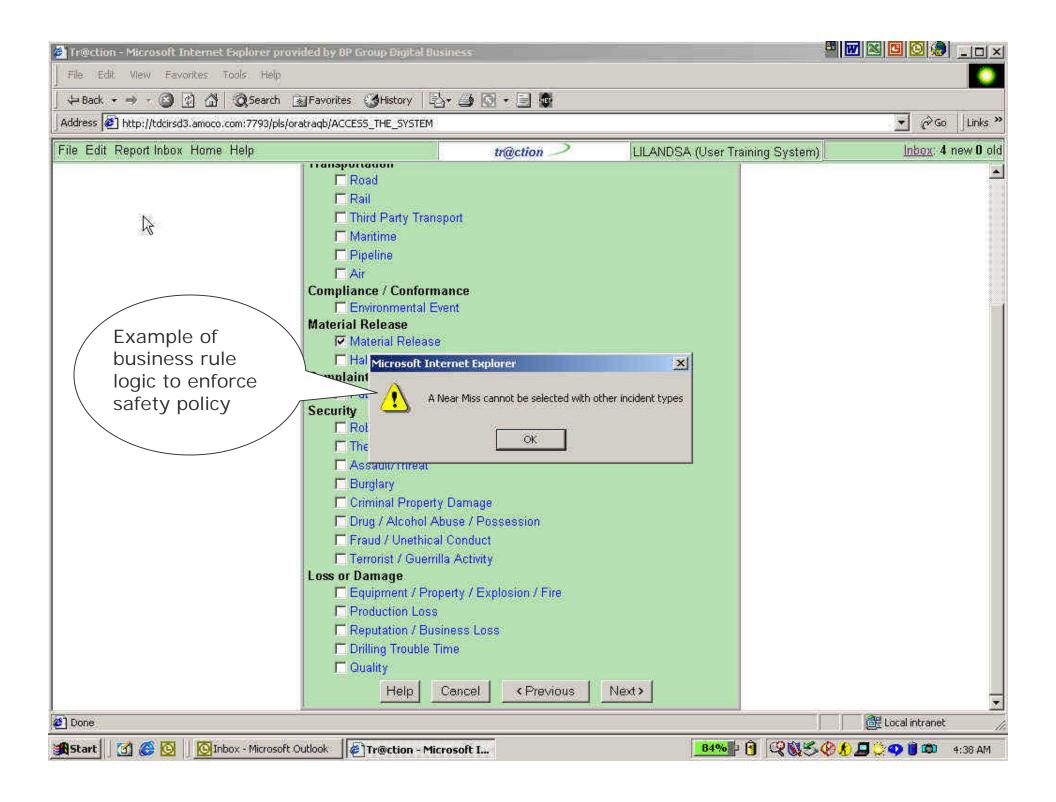


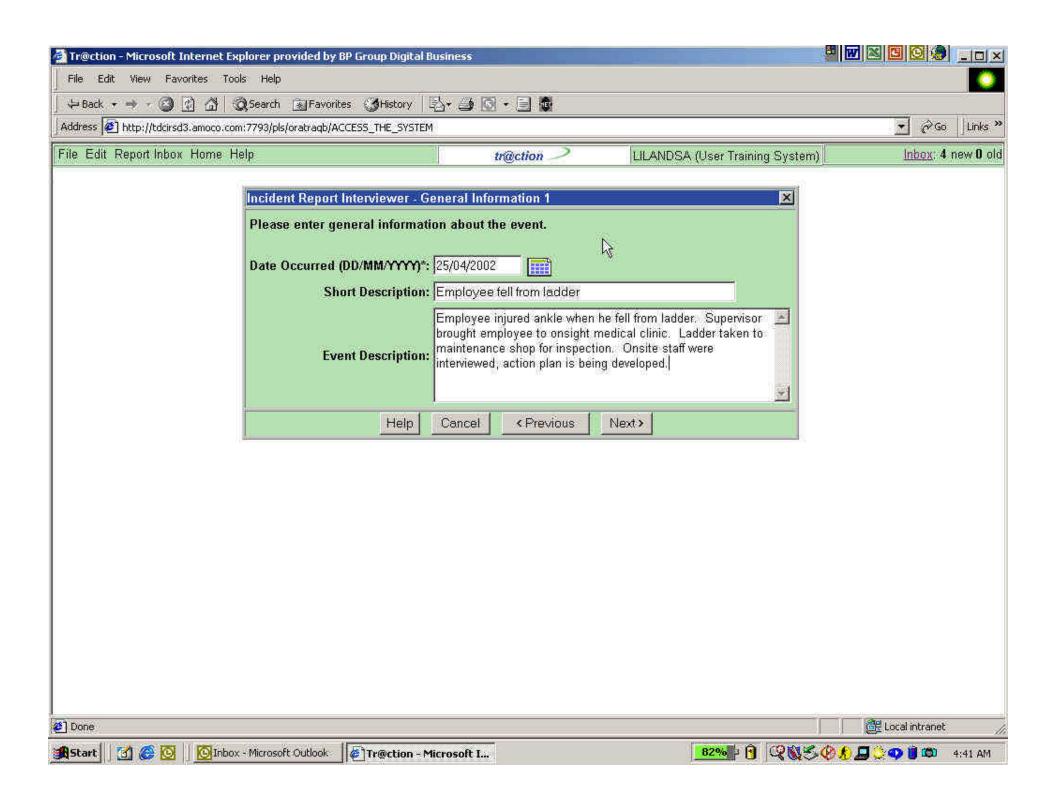
### TR@CTION MAIN PAGE

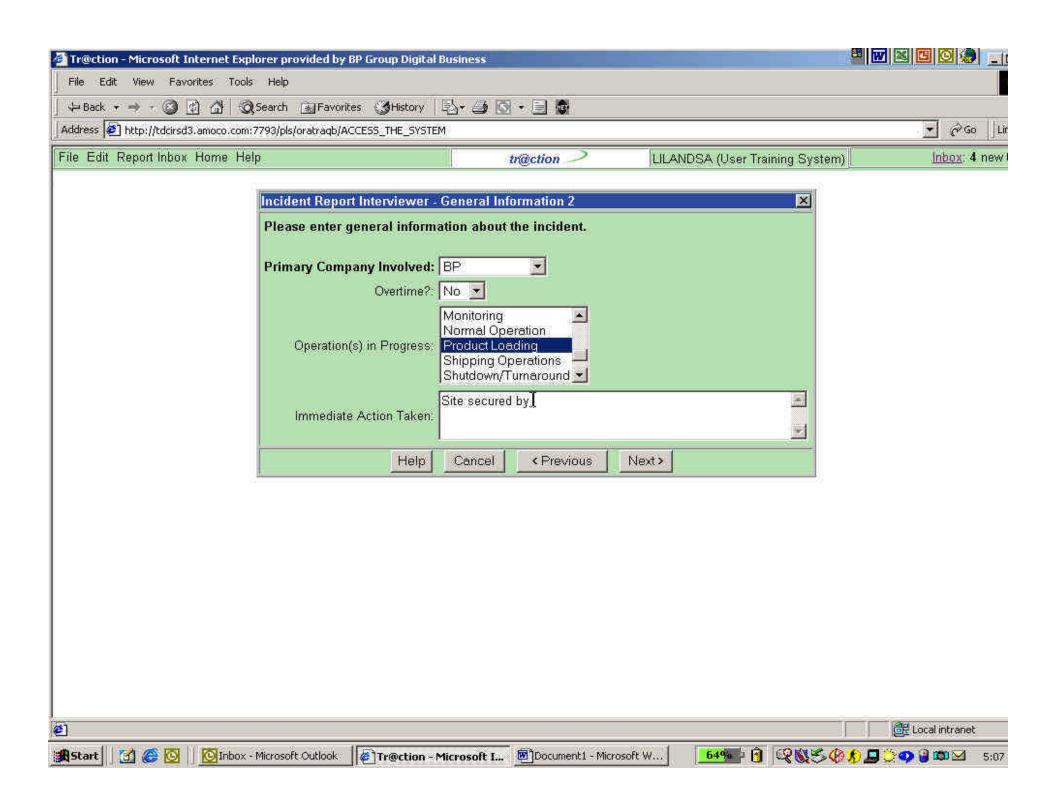


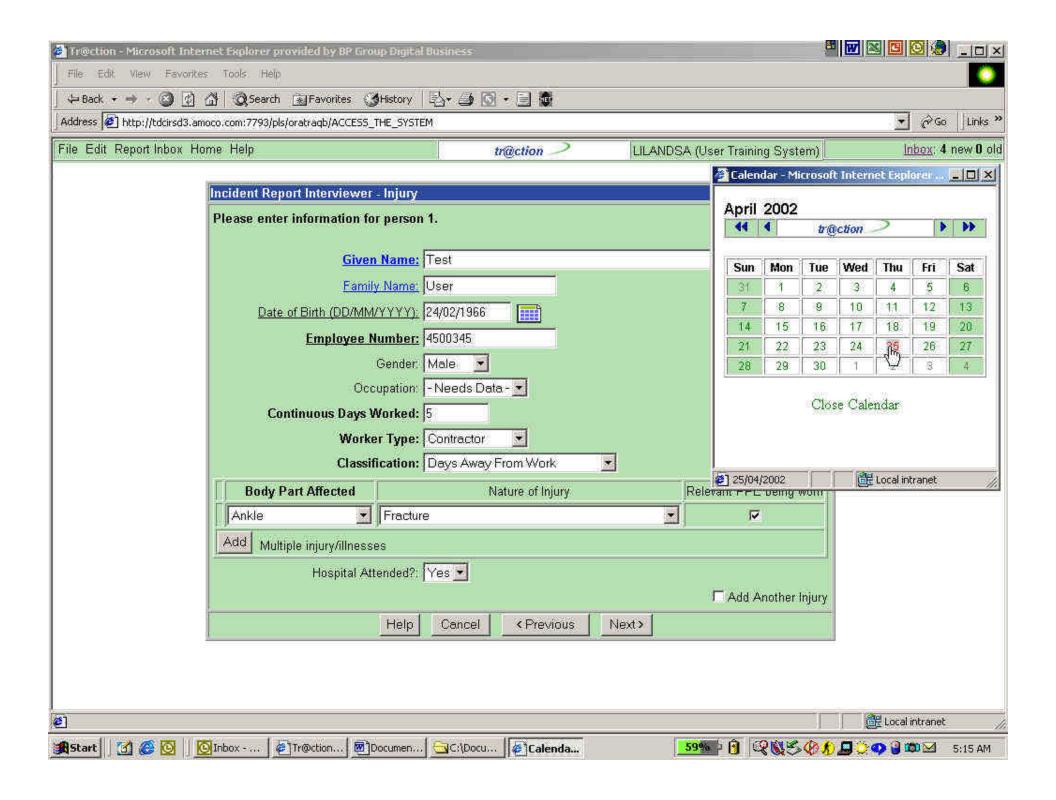
#### Follow the Incident Information Wizard



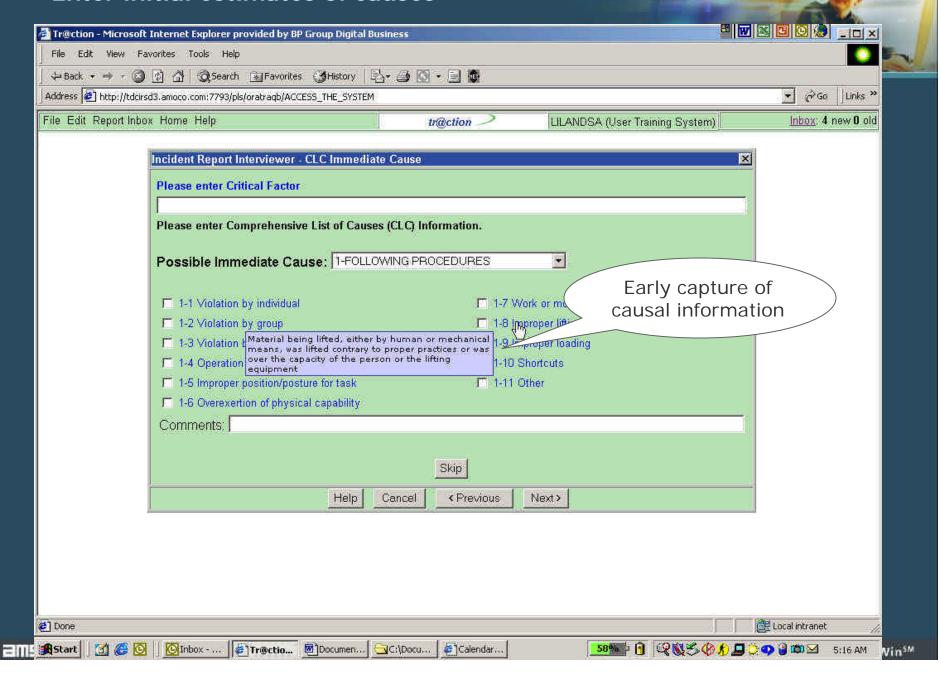




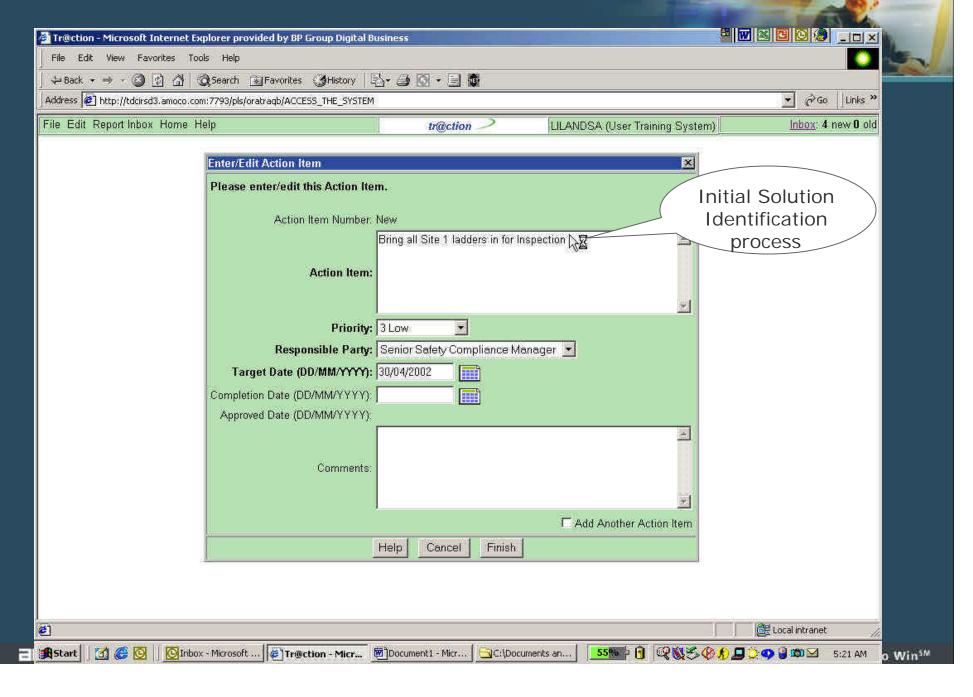


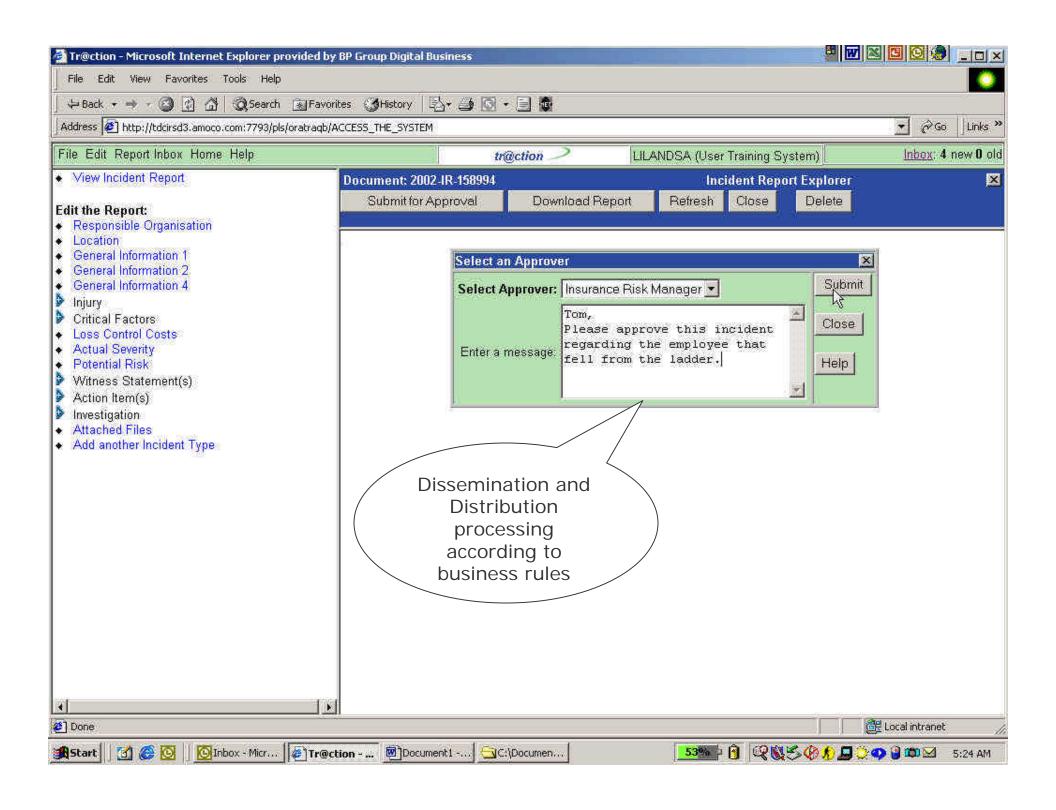


#### **Enter initial estimates of causes**



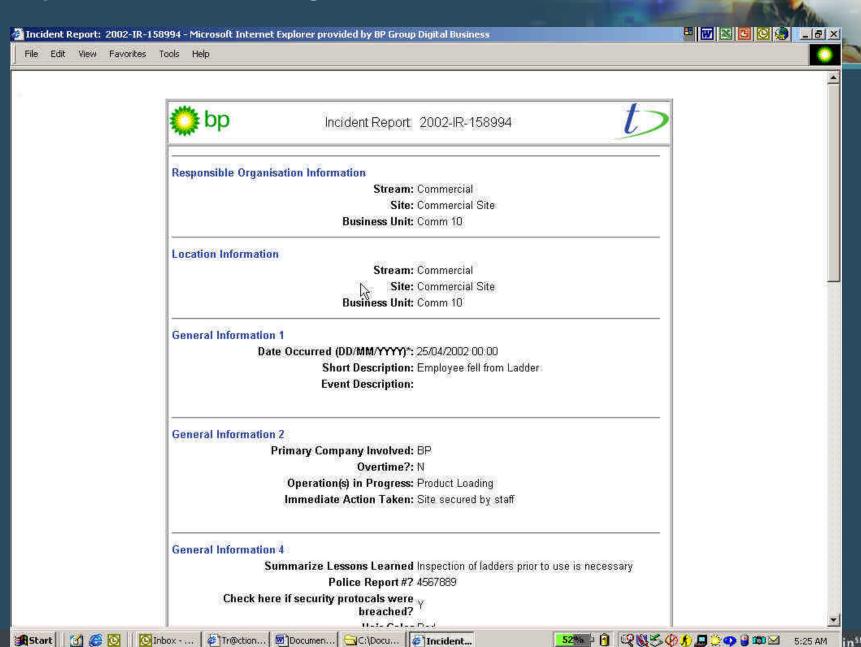
#### Create action items for follow up tracking

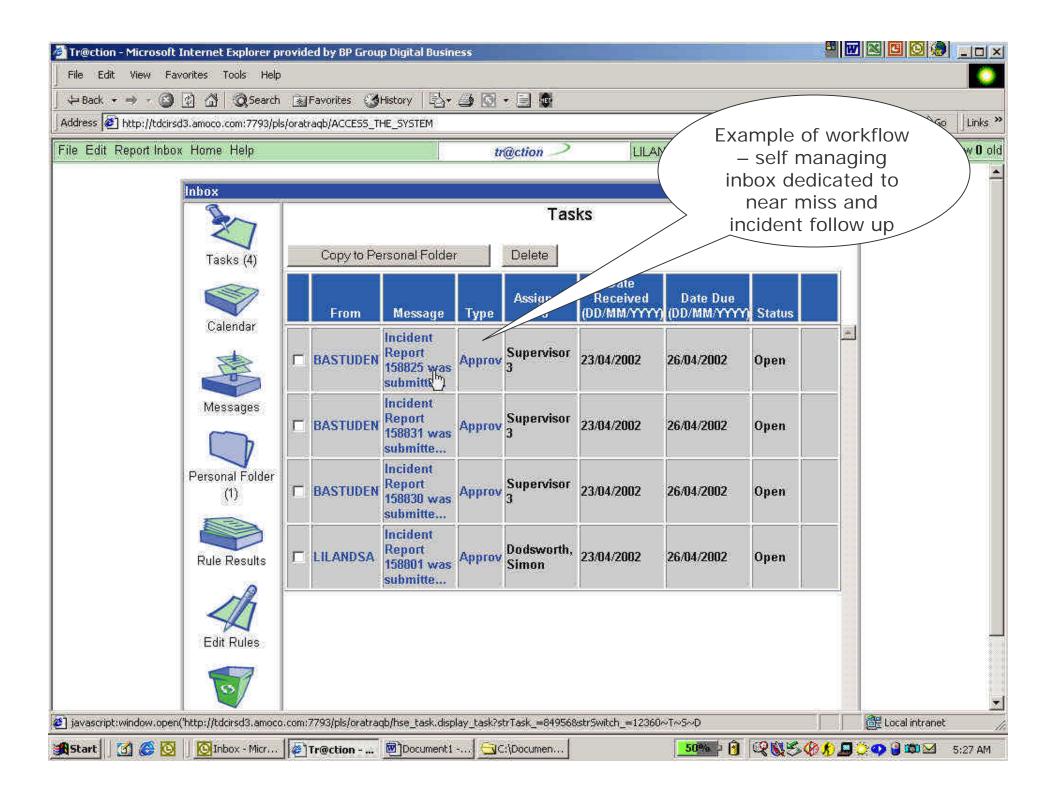




### Reports and workflow mgmt.

3115







Generated on: 19/02/2002



### Open Action Item Aging



February 2002

Stream:

Downstream

Site:

Not Applicable

Business Unit:

BP South Houston

Action Item Category: -A

Aging in month	Priority 1(HIGH)				Priority 2(MEDIUM)				Priority 3(LOW)																		
	0-6	7-12	13-24	24+	0-6	7-12	13-24	24+	0-6	7-12	13-24	24+	Totals														
ASA	0	ø	0	0	0	0	0	0	0	0	0	0	0														
Audit Event HazOp IR	0 0 0 0	6 0 0	0 0 0	0 0 0	0 0 0 3	D D D	0 0 0	0 0 0	0 0 0 0	0 0 0	0 0 0	6 6 6 0	0 0 0 3														
														Current Totals	0	0	0	0	3	0	0	0	0	0	0	0	3
														Closed during month	1	0	0	0	4	0	0	0	1	0	0	0	6
														Created during month	8				20				6				34

