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Process Safety Forum
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Learning Brief: #020

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Sustained Learning from Process Safety Related Incidents and Near Misses – the Gap between Capture of Events, Reporting, Analysis and 'Not Doing It Again'

This learning brief is shared in order to promote learning and improve safety. You should seek appropriate guidance regarding the relevance, accuracy, and completeness of this alert to your circumstances prior to implementation.

Theme

Culture
Incident reporting & investigation

Summary of Learning

When we examine process safety incidents, or capture Near Misses and Incidents within our own organisations, history tells us that the same, or a similar event is likely to happen again in the future (Lakanal House and Grenfell Tower, Texas City Grandcamp disaster and the Port of Beirut amongst many others). Why is this? What is the gap between the analysis of major events and more minor events within our own organisations, and achieving a sustained change for the better? Organisations need to recognise the barriers and common failings within this learning process.

Description

High hazard organisations are required to provide a process for the recording and analysis of Accidents, Incidents and Near Misses in line duties under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR), and sector-specific (e.g. nuclear site licence), as well as best practice programmes (CIA Responsible Care – Guiding Principles **[1]**). Many organisations are proficient in identifying root causes, and plenty of guidance is available to assist this process **[2, 3]**. Action management is key to this, but this is not the end of the story. Good root cause analysis and timely completion of actions will go a long way to maximise learning from events, but people can still fail to learn if we stop the process there.

Some of the barriers to sustained learning include:

- Failure to embed processes to capture learning from external events and organisations
  As part of chronic unease, follow reliable sources of information, keep well informed and challenge teams in response to new incidents – could that happen here or what parallels apply to our own organisations?

- Difficulty in coding and storing information on Events so that they are easily retrieved when they are needed
  Guidance is available to assist with the coding of Events [4] Effective coding of events should enable the organisation to understand if any repeat events are emerging from the data. Find ways to communicate trends in a visual way, so people understand patterns of near misses and minor incidents etc. and cultivate a state of chronic unease [5]

- Forward actions may be overly-focused on short-term fixes, or easily achievable 'wins', rather than systemic change
  Ensure forward actions will deliver sustained improvement

- Failure to identify all who would benefit from a particular piece of learning, both within and external to an organisation
  Give careful consideration to all groups ad individuals who would benefit from the direct, and indirect lessons to be learned. Share with external organisations. Ensure the search function of your Events database is excellent.

- Failure to communicate in a way that all people will understand, in easily accessible language.
  Think about who the consumers of this information are, and the way in which the learning can be landed most effectively. Make the dissemination of learning a social experience where possible. Use a tool-kit of coaching, mentoring and social learning.

- Failure to communicate using an active form of communication (learning delivered by group email or on-line may limit the extent to which behaviours will change as a result)
  Make time for two-way communication in order to maximise learning. Line managers and supervisors should make adequate time to share learning with their team members. Agreeing such objectives with managers/supervisors, as part of personnel management, is a powerful incentive to make this happen consistently.

- Failure of some of the audience to 'receive and act on' the communication due to disengagement
  Find a trusted individual to deliver the learning to people 'on the ground' – a well-respected peer may do better at getting the message across.

- Failure to disseminate learning to relevant parts of your Supply Chain, and to monitor their level of engagement and safety culture.
  If Suppliers are assessed for their suitability to work with your organisation, include questions on how they record Events, share learning, and how they have adapted their behaviours and practices in response to historic events.

- Information overload and highly distracted working environments
  Too many emails, Teams chats, and back-to-back meetings are the enemy of a learning organisation. Work with your Communications department to drive a culture of well-considered communication and encourage people to flag overload.

- Short Corporate memory
  Use a well-structured, easily searchable database to store and access all learning. Mine the database periodically for historic pieces of learning and remind relevant people and new starters of any problems that happened in the past.

Finally, the Process Safety Forum produce a range of Learning tools to assist organisations, including Learning Briefs, Knowledge Exchange and Incident Reviews. This material is freely available on the PSF website [7].

Further reading

[1] CIA Responsible Care. Guiding Principles.

[2] RoSPA Learning from Safety Failure

[3] HSE HSG 245 Investigating accidents and incidents A workbook for employers, unions, safety representatives and safety professionals [4] HSE HSG 245 Investigating accidents and incidents A workbook for employers, unions, safety representatives and safety professionals

[4] OELG Event Categories
https://www.nuclearinst.com/write/MediaUploads/SDF%20documents/Operating%20Experience/OELG_Event_Codes.pdf

[5] HSE High Reliability Organisations – A Review of Literature

[6] The Learning Imperative. M Burns and A Griffith, 2018.

[7] Process Safety Forum: various process safety learning material. http://www.p-s-f2.org.uk/