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NEAR MISS PROCEDURES

1. DEFINITION (AS PER ISM CODE)

Near-miss: A sequence of events and/or conditions that could have resulted in loss. This loss was prevented only by a fortuitous break in the chain of events and/or conditions.
The potential loss could be human injury, environmental damage, or negative business impact (e.g., repair or replacement costs, scheduling delays, contract violations, loss of reputation).

Some general examples of a near-miss are as follows:

i. Any event that leads to the implementation of an emergency procedure, plan or response and thus prevents a loss. For example, a collision is narrowly avoided; or a crew member double checks a valve and discovers a wrong pressure reading on the supply side.

ii. Any event where an unexpected condition could lead to an adverse consequence, but which does not occur. For example, a person moves from a location immediately before a crane unexpectedly drops a load of cargo there; or a ship finds itself off-course in normally shallow waters but does not ground because of an unusual high-spring tide.

iii. Any dangerous or hazardous situation or condition that is not discovered until after the danger has passed. For example, a vessel safely departs a port of call and discovers several hours into the voyage that the ship's radio was not tuned to the Harbour Master's radio frequency; or it is discovered that ECDIS display's scale does not match the scale, projection, or orientation of the chart and radar images.

A near-miss is seen as an undesired event, which under slightly different conditions could have resulted in an accident. A Near Miss is often referred to as 'Hazardous Occurrence'.

Near miss event occurs generally as a result of unsafe act, unsafe conditions or lapse of judgement.

Unsafe Act is an act, which varies from the accepted safe practice and creates a hazard to persons, property or environment. To reduce unsafe acts, it is essential each crew member to make a conscious effort to work safely despite the hazardous conditions that may exist at any site on board the ship.

An unsafe Condition is defined as a condition, which varies from a normal safe condition and, if not corrected could lead to an accident. It is difficult to eliminate all unsafe conditions and it is even more difficult to predict or anticipate where such conditions may exist or develop on board. However, the best way to eliminate unsafe conditions is to make the crew aware of conditions that can contribute to a near miss or accident and then to remove exposure to these conditions.

The dividing line between a 'NEAR MISS' and 'ACCIDENT' is the 'THRESHOLD LIMIT'. If the Threshold limit is crossed, it is an accident else a near miss.

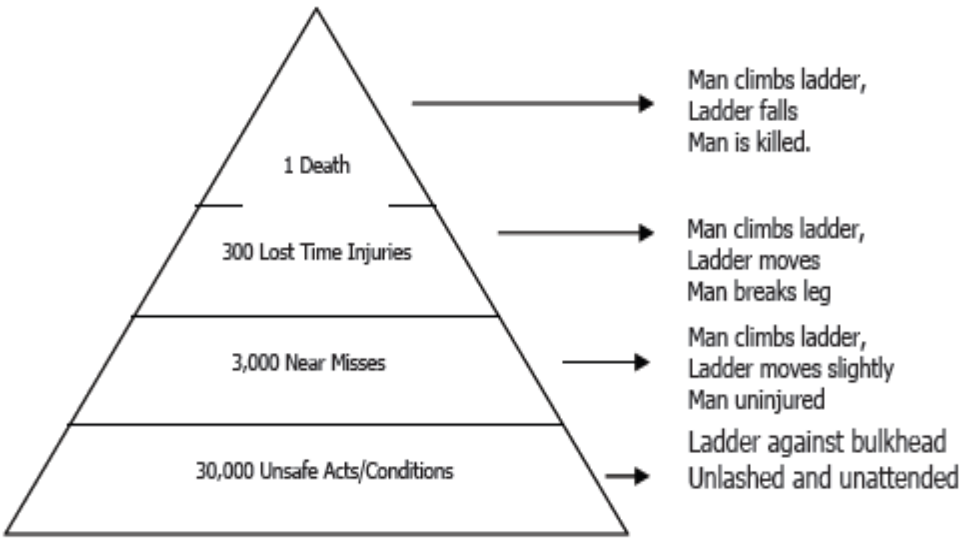
For a material, any kind of damage, deformation, or other change from initial state, indicates that the threshold limit has been crossed.

For a person, any pain / bruise / cut or other injury indicates that threshold limit has been crossed or exceeded.

2. BENEFITS OF REPORTING NEAR MISS INCIDENTS

In order to examine the importance of near misses, let us look at the following model:

It can be seen from the example that for every death there are 3,000 near misses and 30,000 unsafe acts and unsafe conditions.



Study of near misses can therefore be used to prevent more serious incidents and to improve safety performance. By reducing the number of near misses, the chances of injury and/or death can be reduced.

Near miss reporting also makes good business and economic sense as it can improve vessel and crew performance and, in many cases, reduce costs.

Therefore, it follows that near miss reporting has an important role in incident prevention. Without a healthy reporting culture, there is a potential for lost opportunities to improve safety performance.

Learning from the lessons from near miss shall help to improve safety performance since near misses can share the same underlying causes as losses.

The ultimate objective of near-miss reporting and investigating is to identify areas of concern and implement appropriate corrective actions to avoid future losses. To do so requires that reports are to be generated, shared, read, and acted upon.

3. OVERCOMING BARRIERS TO REPORTING NEAR MISS

In the majority of the cases the near misses are only known by the individual(s) involved who chose to report or not the incident. Some of the main barriers to the reporting of near misses include the fear of being blamed, disciplined, embarrassed, found legally liable or to avoid paper work.

In order to improve the safety system and minimize operational risks and known deficiencies, company encourages the reporting of all Hazardous Occurrences (Near Misses) by adopting a “just culture approach”.

A “just culture” features an atmosphere of responsible behavior and trust whereby people are encouraged to provide essential safety-related information without fear of retribution.

In order to achieve success in obtaining Near Miss Reports, it is important that the staff feels confident that the reporting will not be held against any persons. It is important that this assurance is not betrayed.

In this respect, the company maintains a blame free environment, ensures that the staff feels confident that the reporting will not be held against any persons. Company also assures that near miss reporting will not result in punitive measures.

Repeat offenders, who have been cautioned, will be reprimanded.

4. REPORTING NEAR MISS INCIDENTS

There can be many near misses for every single accident that occurs on board ship and it is only by identifying them and learning from them that we can hope to avoid accidents happening in the first place. Accordingly, the importance of reporting near misses cannot be over emphasized.

The company safety culture encourages detailed reporting, especially of near misses.

We therefore request the cooperation of all our ships staff in reporting each and every near miss incident. Senior Management should lead by example and encourage near-miss/hazardous occurrences reporting.

Even if one incident can be prevented due to your near miss report, you have done a great service to your seafarer colleagues.

Each near miss incident shall be reported to head of department who shall ensure that the detailed report is made in CFM[1].

The Master / Chief Engineer is responsible for the timely reporting of all near misses to the company. The Company requires that all Hazardous Occurrences (Near Misses) are reported to the office as soon as Possible but no later than one week after the occurrence of the event.

It must be emphasized that near miss reporting is not to be viewed as personal criticism but the lessons learnt can contribute to the safety of life onboard.

These reports (with findings and recommendations) should be discussed in the next HSQE Committee meeting or other appropriate opportunities with all staff to prevent recurrence.

5. INVESTIGATING NEAR MISS INCIDENTS

Investigating near-misses is an integral component of continuous improvement in safety management systems. This benefit can only be achieved when seafarers are assured that such reporting will not result in punitive measures.

Investigating near-misses can help us understand safety problems and make corrective changes before an accident takes place and will help maintain effective defenses to prevent safety and environment related incidents.

Every Near Miss shall be analyzed and investigated onboard for the potential for loss as well as the possibility of reoccurrence. This helps in focusing attention on the important issues.

Master and/or Chief Engineer are responsible for investigation of near miss and to ensure effective implementation of actions to prevent recurrence. Any further comment by the shore office will be sent to the ship, if found necessary.

Company will review and close the near miss report and ensure near miss reports are managed correctly.

All near miss reports will be closed within 3 months. If unable to close within this time frame, extension shall be obtained from Marine Manager stating valid reasons.

All near misses shall be managed similar to an incident in the identification of causes and preventive measures.

Company shall also review and analyze all near-misses as an integral component of continuous improvement in HSQE management systems.

[1] W 30 / 2024

Significant near miss incidents shall be shared with the fleet via CFM[2] for discussion onboard and to avoid repetition of similar incidents.

All near miss reports shall be reviewed quarterly by HSQE manager and statistics will be provided to top management. During annual management review, targets and KPIs for the year are set to monitor the effectiveness of the corrective actions.

All near miss reports shall be captured for trend analysis. The objective of analysis is to identify trends from incidents. From these trends, aims and objectives will be produced for agreement during the annual management review. This will enable the most effective actions to be carried out to reduce losses in the future.

Analyzing near miss reports helps incorporating better and more effective controls and best practices into our HSQE management system and helps us identify areas where we lack and need more focus.

The feedback analysis and statistics of all near miss reports will be forwarded throughout the fleet. For continual improvement and to prevent recurrence of these near miss incidents, company shall plan for changes to Strategy, Polices, PMS, Changes to Manuals, provide new procedures, issue fleet advisory/circular, provide further training, discuss the issue during sea staff seminars, identify best practice etc as applicable.

[2] W 30 / 2024