10th Safety Gala Albania

TIRANA INTERNATIONAL SAFETY CONFERENCE

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RISK MANAGEMENT & EHSS CONSULTANCY SERVICES

SAFETY SYNERGY

Competence, Growth & Sharing

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4TH OF DECEMBER 2025

THE HIDDEN COST OF NEAR MISSES

Transforming Minor Events into Major Lessons

Presented by:
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AGENDA

01 What Is a Near Miss?

02 Global Case Studies

03 The Hidden Costs and Risks

04 Our Current Near Miss System

05 Investigation Process

06 Corrective Actions

07 Digitalization

08 Closing Message

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KEY DISTINCTIONS:

NEAR MISS:

Unsafe event with no consequences

INCIDENT:

Event with minor consequences

ACCIDENT:

Event that results in injury, damage, or harm

WHAT IS A NEAR MISS?

A near miss is an unplanned event that did not result in injury, damage, or loss, but had the potential to do so.

Examples:

- A falling object landing close to a worker
- A slip where the person regains balance
- Equipment malfunction caught just in time

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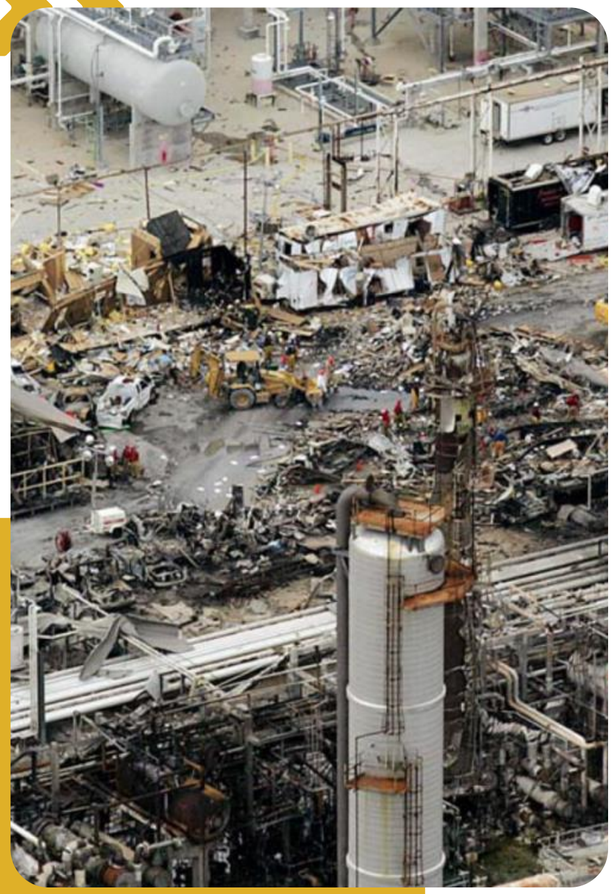
WORLDWIDE NEAR MISSES THAT TURNED INTO MAJOR ACCIDENTS

BP TEXAS CITY REFINERY EXPLOSION (USA, 2005)

Hidden Cost Lesson:
The facility had dozens of near misses over the years. None were treated as leading indicators.



NEAR MISSES BEFORE THE ACCIDENT:

- Multiple **previous vapor releases**
- **Alarms** that frequently **malfunctioned** but were ignored
- Operators repeatedly **bypassing safety systems**
- Reports of **unsafe startup procedures**

FINAL ACCIDENT:

- **Explosion** during start-up of the isomerization unit
- **15 fatalities**, 180+ injured
- **$1.5 billion** in fines, lawsuits, and shutdown costs

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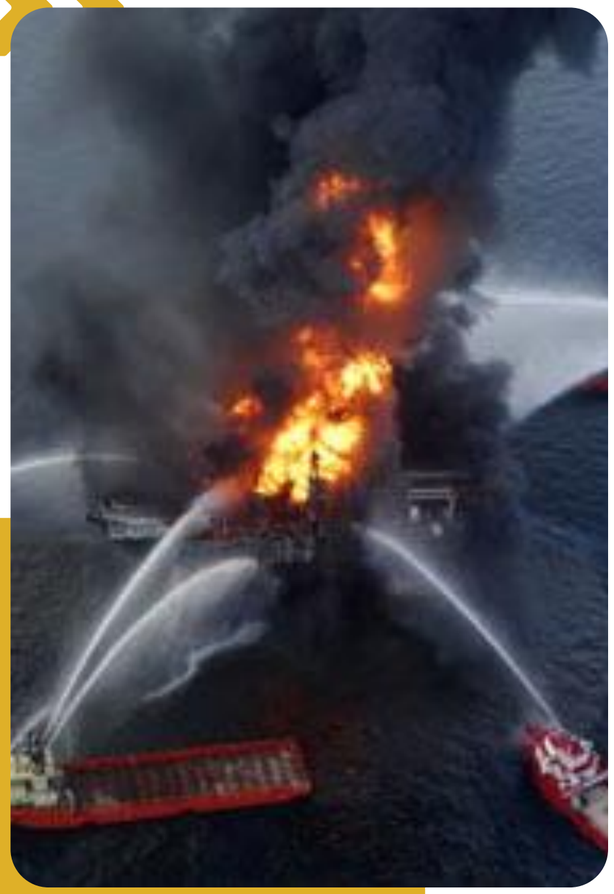
WORLDWIDE NEAR MISSES THAT TURNED INTO MAJOR ACCIDENTS

BP DEEPWATER HORIZON (GULF OF MEXICO, 2010)

Hidden Cost Lesson:
Technical near misses were overshadowed by schedule pressure and “normalization of deviance.”



NEAR MISSES BEFORE THE ACCIDENT:

- **Repeated small leaks** and “kick” events on the rig
- **Pressure** test **irregularities**
- A **failed blowout preventer** that had almost malfunctioned before
- Culture of **rushing deadlines**

FINAL ACCIDENT:

- Blowout, **explosion**, and **oil spill**
- **11 fatalities**, 4.9 million barrels of oil spilled
- **$65+ billion** in total costs

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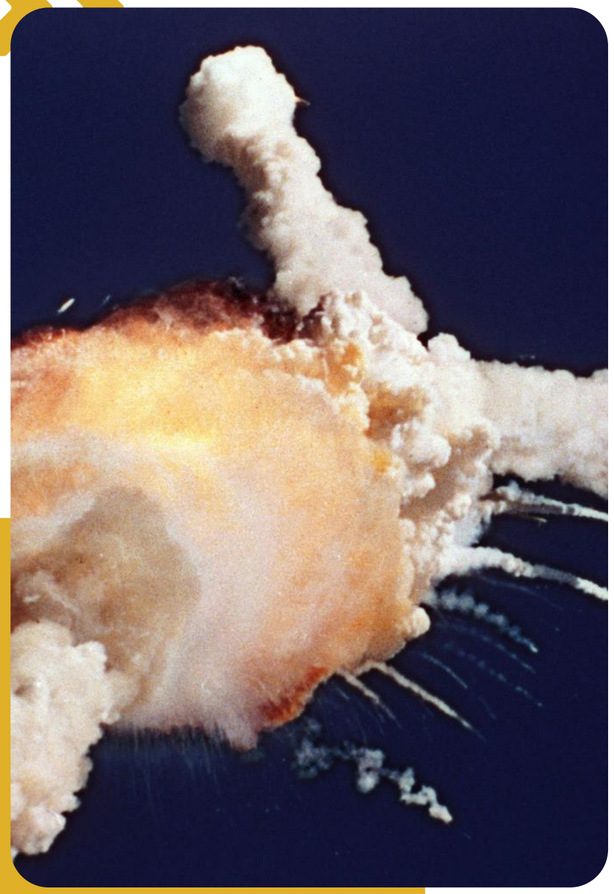
WORLDWIDE NEAR MISSES THAT TURNED INTO MAJOR ACCIDENTS

NASA SPACE SHUTTLE CHALLENGER (1986)

Hidden Cost Lesson:
A known near miss was treated as "acceptable risk" — and became a fatal one.



NEAR MISSES BEFORE THE ACCIDENT:

- Engineers warned about **O-ring erosion in prior missions**
- Previous **temperature-sensitive seal failures**
- **Documented near misses** where the O-ring partially failed
- **Concerns** repeatedly raised but **overridden**

FINAL ACCIDENT:

- **Shuttle disintegrated** 73 seconds after launch
- **7 astronauts killed**

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THE HIDDEN COST

EVEN WITHOUT INJURY, NEAR MISSES COST US IN:

DISRUPTIONS IN OPERATIONS

STRESS AND UNCERTAINTY AMONG WORKERS

REPEATED EXPOSURE TO THE SAME HAZARD

INCREASED PROBABILITY OF FUTURE INCIDENTS

FALSE SENSE OF SAFETY

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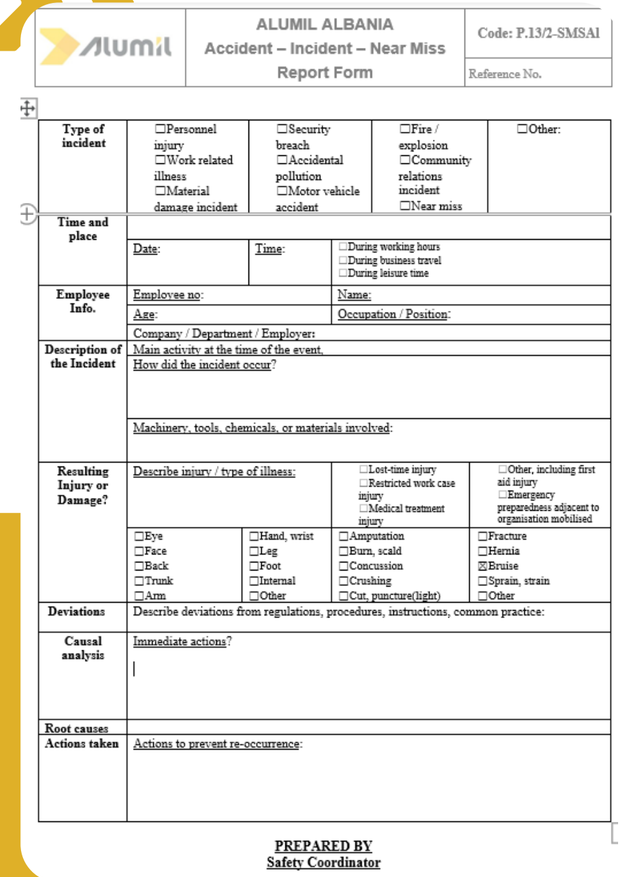
OUR NEAR MISS REPORTING SYSTEM

EVERY EVENT IS DOCUMENTED THROUGH A NEAR MISS FORM.

- DESCRIPTION OF EVENT
- PHOTOS (IF NECESSARY)
- LOCATION & TIME
- PROPOSED CORRECTIVE ACTIONS
- IMMEDIATE ACTIONS TAKEN
- ROOT CAUSES



Alumil	ALUMIL ALBANIA Accident – Incident – Near Miss Report Form	Code: P.13/2-SMSAl Reference No.

Type of incident	☐Personnel injury ☐Work related illness ☐Material damage incident	☐Security breach ☐Accidental pollution ☐Motor vehicle accident	☐Fire / explosion ☐Community relations incident ☐Near miss	☐Other:
Time and place				
	Date:	Time:	☐During working hours ☐During business travel ☐During leisure time	
Employee Info.	Employee no:		Name:	
	Age:		Occupation / Position:	
	Company / Department / Employer:			
Description of the Incident	Main activity at the time of the event.			
	How did the incident occur?			
	Machinery, tools, chemicals, or materials involved:			
Resulting Injury or Damage?	Describe injury / type of illness:		☐Lost-time injury ☐Restricted work case injury ☐Medical treatment injury	☐Other, including first aid injury ☐Emergency preparedness adjacent to organisation mobilised
	☐Eye ☐Face ☐Back ☐Trunk ☐Arm	☐Hand, wrist ☐Leg ☐Foot ☐Internal ☐Other	☐Amputation ☐Burn, scald ☐Concussion ☐Crushing ☐Cut, puncture(light)	☐Fracture ☐Hernia ☒Bruise ☐Sprain, strain ☐Other
Deviations	Describe deviations from regulations, procedures, instructions, common practice:			
Causal analysis	Immediate actions?			
Root causes				
Actions taken	Actions to prevent re-occurrence:			

PREPARED BY
Safety Coordinator

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OUR INVESTIGATION PROCESS:

THE NEAR MISS FORM SUPPORTS EACH STEP TO ENSURE NOTHING IS OVERLOOKED.

- Immediate communication
- Area secured
- Photos & facts collected
- Root cause identified
- Corrective actions implemented
- Follow-up verification

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CORRECTIVE ACTIONS THAT WORK

EXAMPLES OF IMPROVEMENTS BORN DIRECTLY FROM NEAR MISS FORMS:

- **Physical guards** on pinch points
- Updated **work instructions**
- Safer **storage** layout
- More **inspections**
- Low-cost **fixes** (markings, rails)
- Better **visibility**
- Quick-response **PPE stations**

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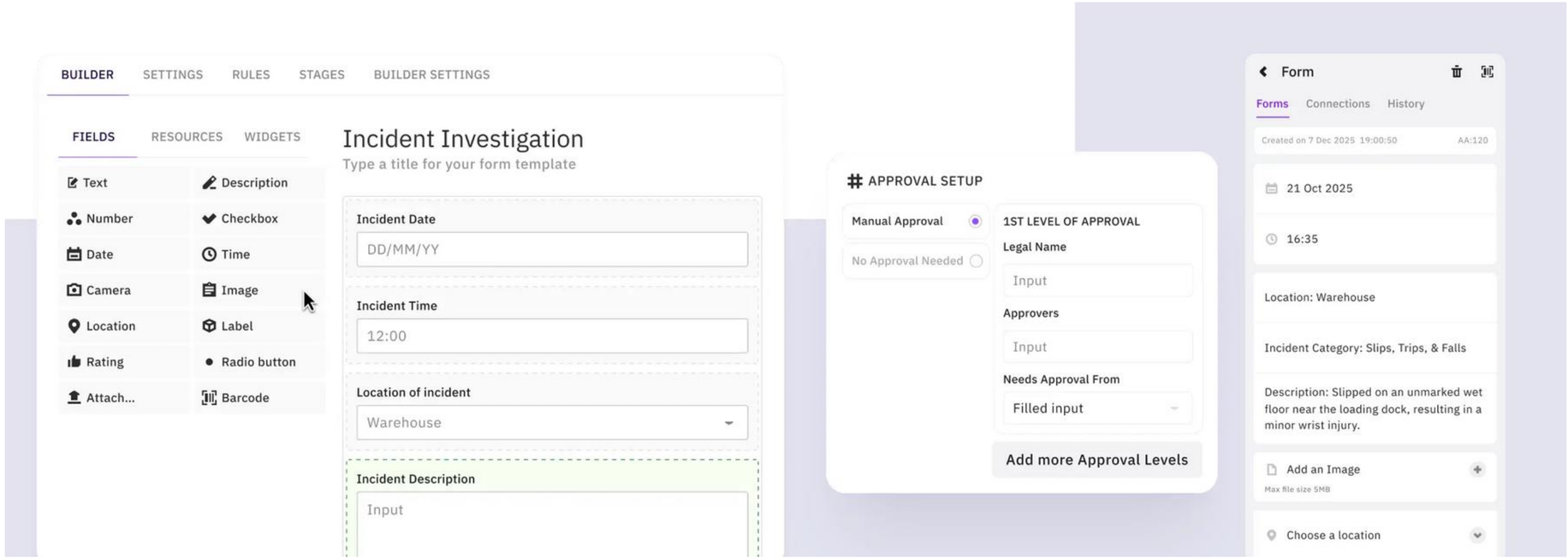

OUR NEXT STEP TOWARD DIGITAL SAFETY (2026)

Tekmon is a **digital platform** that simplifies and standardizes safety reporting. Not yet implemented but planned as our main Near Miss digitalization step in 2026.

WHY WE ARE EXPLORING TEKMON:

- Supports a **stronger reporting culture**
- Enables **simple mobile submissions**
- Reduces **delays** & missing info
- Improves **traceability** of actions
- Enhances **visibility** for supervisors

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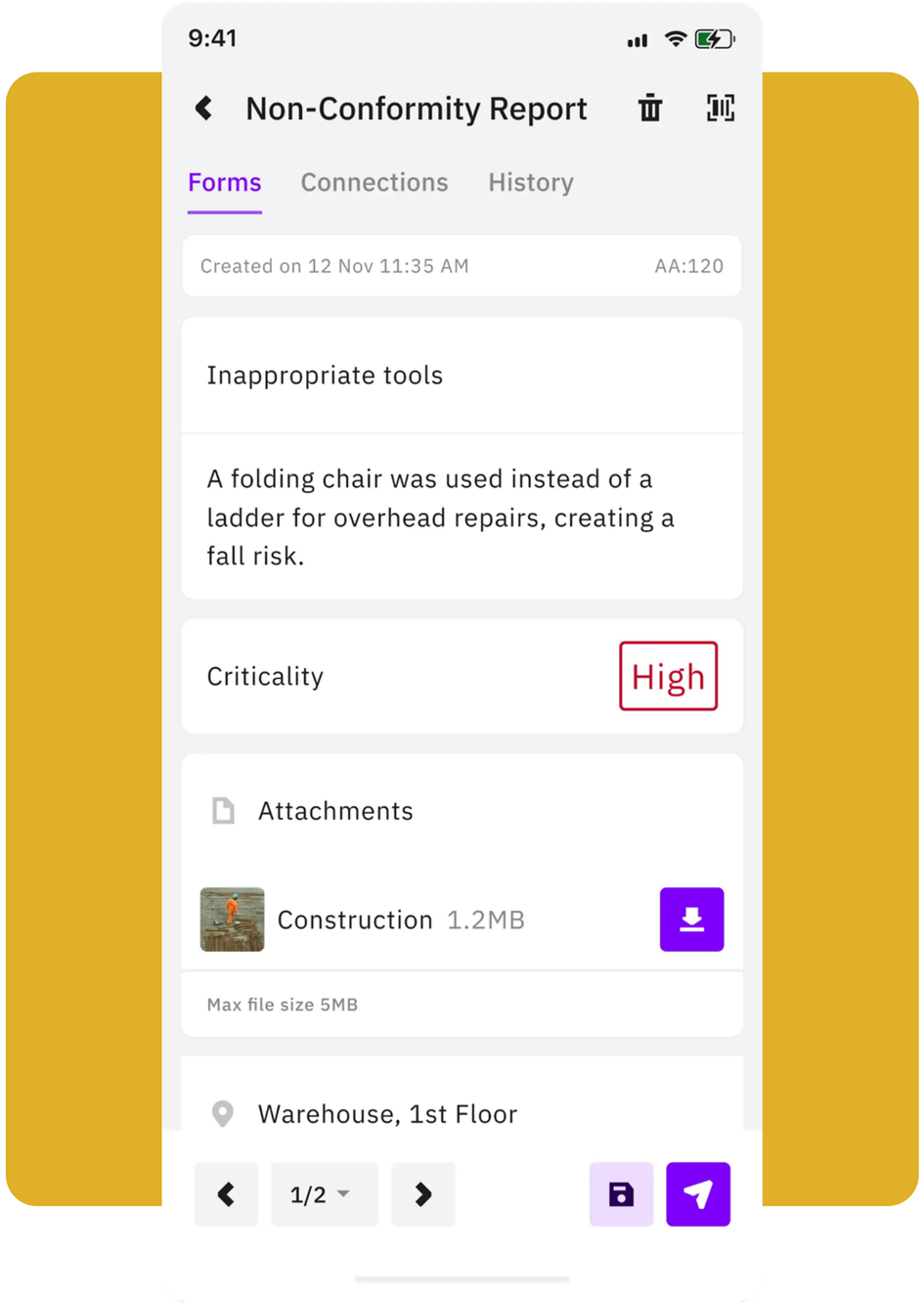

DIGITAL REPORTING OF NEAR MISSES

As part of our 2026 roadmap, we aim to adopt Tekmon to simplify and standardize Near Miss documentation.

WITH A MOBILE APP, WORKERS WILL BE ABLE TO:

- **Instant** Near Miss reporting
- **Real-time** photo & evidence upload
- **Auto-capture** of date, time & location
- Direct to the **Safety team**
- **Structured** investigation workflow
- **Automated** notifications & reminders
- **Real-time** status tracking
- Corrective actions with **clear deadlines**

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CULTURAL SHIFT IN OUR SITE:

- **Reporting is rising yearly**
- Workers feel **more comfortable** speaking up
- Supervisors treat Near Misses as **priority signals**
- Management responds **faster** thanks to documentation
- **Digitalization (Tekmon)** will elevate this further

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- **Near Misses = silent alarms.**
- If we **listen**, we prevent accidents.
- **Structured reporting** turns small events into lessons
- **Digital tools** make learning faster & more accurate
- “Safety improves not when incidents stop happening, but when **people start talking**.”

CONCLUSION:

What we ignore today becomes what we regret tomorrow.

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