THE NEAR-MISS PARADOX

By Sid Heal

Good teams are successful. Indeed, being successful is part of the definition of being good. It is somewhat ironic, then, that the more successful they are, the more susceptible they are to overconfidence. While overconfidence can result from many factors, one particular variety affects good teams more than others. This is called the "near-miss paradox." A near miss is any unplanned event that could have turned out badly but did not. Other common terms describing this phenomenon are close call, narrow escape, close shave, white knuckler or a near hit. The most serious are often referred to as cheating death. Regardless of the nature of a near miss or how it is described, it refers to a situation that, for whatever reason, avoided a catastrophe.

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Ironically, these events send mixed messages. Some see them for what they are — near tragedies to be avoided in whatever manner possible. Many others, however, confuse them with success and see them as proof that their decisions and actions were sound and effective, which was why the potential tragedy was averted. And so a paradox is revealed in that the more often someone experiences a near miss, the more likely they are to repeat risky behavior.[1] The near-miss paradox is the perception that a near tragedy validates the actions that led to it.[2]

Sadly, the near-miss paradox is prevalent in the safety services, especially in law enforcement, where dodging a bullet has long been a bromide that soothes without necessitating further examination. That is not to say, however, that they don't exist. Perhaps the most common near-miss reporting in law enforcement is a requirement to report discharges of firearms, regardless of the circumstances. These shots fired incidents are then scrutinized for policy and training issues. Likewise, recognizing that accidents will happen, these practices have resulted in corrective measures for accidental discharges, such as loading barrels outside buildings and procedures to reduce the likelihood of injury when they do occur.

When thought of as signals rather than events, near misses serve as harbingers for analysis. After all, a near miss is the same thing as a near hit. As a point of fact, near misses have long been recognized in the business world as free lessons, since applying corrective measures before an accident avoids their adverse consequences. Studies have indicated that for every serious injury accident there were as many as 10 similar incidents with lesser injuries and 30 more with no injuries.[3] Had the hazards been identified and rectified, the serious injury was far less likely to occur and far less injurious if it did occur.

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A near-miss management program provides several advantages, not the least of which is identifying hazards before they result in tragedy. Like the yellow flag on a racetrack, known hazards beg for precautions. Another advantage is that investigations can be conducted without the emotional context of tragedy. Human nature makes it difficult to criticize behaviors that resulted in serious injury and accidental deaths, particularly if the one who blundered personally suffered the

terrible price. The feelings that further criticism is simply rubbing salt into the wounds perpetuates the likelihood that the hazards will remain unknown and uncorrected. Still another advantage is identifying hot spots. A hot spot is simply a place or time in which trouble is expected. Imagine a driver who slows way down for a blind curve in foggy weather or darkness or because he or she recognizes the potential for trouble. Similarly, a tactical team might arrange for an ambulance and medical assistance to be available during a high-risk operation. People who are aware of hazards can take precautions to compensate for them, even when they cannot be eliminated.

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In the simplest form, a near-miss management program has only two steps. Understandably, the first step begins with a reporting system. This is harder than it sounds since people who call attention to potential problems, especially those without injury or damage, are rarely enthusiastically received. Consequently, it is sometimes necessary to build a reporting system that is confidential, or even anonymous. It is also necessary to determine whether such reports should be mandated or voluntary. Regardless of the conditions, the critical criterion is the emphasis on ensuring that all near misses (or as many as practical) are reported in such a manner that they can be examined either as an isolated incident or in the context of similar incidents.

The second step is an analysis to determine things such as whether the near miss was an isolated incident or part of a trend; whether it was preventable or some inherent condition that needs to be considered for planning, policy or training; whether it resulted directly from a proximate cause or has deeper, root causes that also need to be addressed; whether it can be resolved at a local level or will require a broader remedy; and so forth. The critical focus of this step is the identification and correction of deficiencies before they result in calamity.

While detractors will be quick to repudiate the advantages of tracking something that did not happen, finding out after someone has been hurt or killed that the conditions were simply an accident waiting to happen or a recipe for disaster is sure to arouse greater wrath for failing to recognize and address hazards that should have been anticipated. There is a big difference between taking a calculated risk and being blindsided. As someone once said, "Prepare and prevent, don't repair and repent."[4] ■

ENDNOTES

1. This phenomenon has been studied and reported on in the business community by Dr. Catherine Tinsley of the McDonough School of Business at Georgetown University in Washington, D.C.

2. This same flawed thinking is similar to that which supports the gambler's fallacy, which holds that something that happens more frequently than normal during some period will happen less frequently in the future, and vice versa. Thus, it can be rationalized that another near miss in a series of near misses is less likely rather than more likely to reoccur. This misconception reinforces the paradox in that there seems to be no need for additional analysis (or corrective action) and so the actions and behaviors which led to it are more likely to be repeated until some tragedy compels scrutiny.

3. Tinsley, Catherine H., Robin L. Dillon and Peter M. Madsen. "How to Avoid Catastrophe," *Harvard Business Review*, April 2011.

4. Author unknown.

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