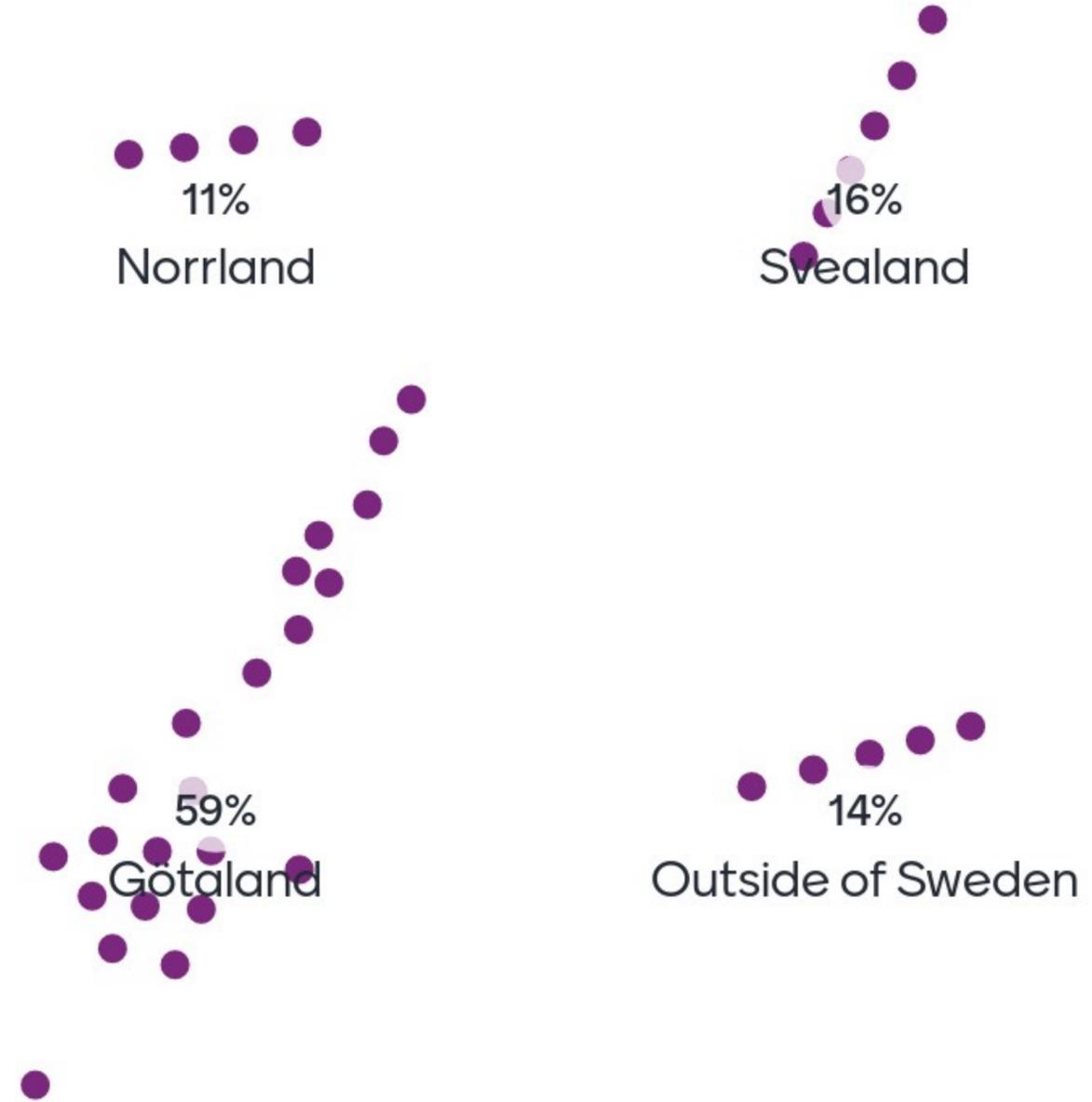
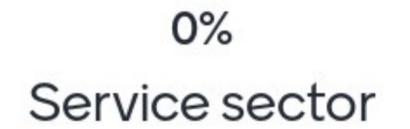


# Where do you live and work?



# What is your industrial sector?





# Have you heard about Herbert William Heinrich?



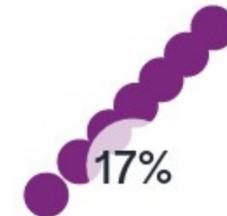
No, not really



Yes, but I don't know much about him

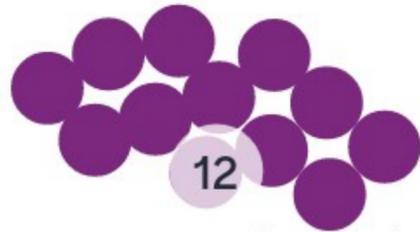


Yes, I know some of his models and metaphors



Yes, I have read some of his work

# Which of the following ideas can be attributed to Heinrich?



The accident sequence can be illustrated by a row of dominos tumbling



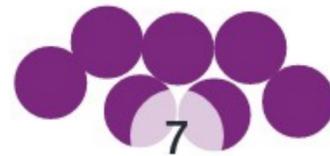
All accidents are preventable



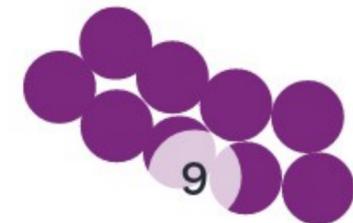
On average, there are more near-misses than accidents with injury



When an accident happens the hidden costs are much larger than the direct damage or injury



The root-cause of most accidents is human error



Accidents happen because barriers are imperfect and when these failures line up

# My organisation's incident reporting and management system is used for (answer all applicable)



Reporting statistics to regulator and management



Looking at trends to identify problems in our systems



Finding causes of incidents and fixing them



Tracking improvement actions



Helping organisational learning



My organisation does not have an incident reporting and management system

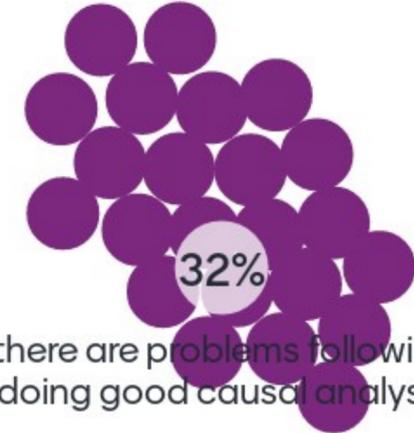
# Do you recognise some of the challenges with incident reporting and management system (answer all applicable)



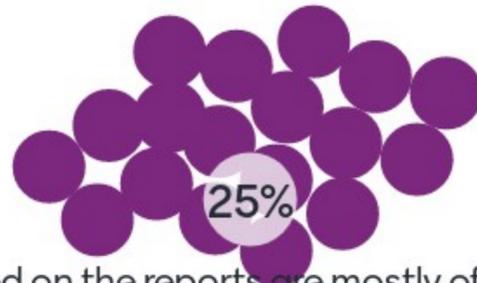
Our system suffers from serious underreporting



There are many reports that do not really contribute to improving safety



People report, but there are problems following up on reports and doing good causal analysis



Actions based on the reports are mostly of the "fixing the immediate problem". We rarely go deep towards root causes



The system is only used for single cases, we rarely look at trends