

# Near-Miss Reporting in Canada Should Be More Than a Paper Exercise



A worker walks under a mezzanine just seconds after a tool falls to the floor. A delivery driver slips on ice but catches himself before striking his head. A forklift reverses into a blind corner and stops just before hitting a pedestrian. A machine jams, the worker reaches instinctively toward the point of operation, and a co-worker yells before contact occurs. No one is injured, so the workplace moves on.

That's where many organizations make the mistake. They treat the event as minor because the outcome was minor, when the outcome may have been minor only because of luck. Near misses are not low-value reports. They're early warnings that reveal hazards before the worst consequence occurs. In Canadian OHS, that matters because employers have a legal duty to identify hazards, assess risks, implement controls, and take reasonable precautions to protect workers.

CCOHS states that workers should report actual or potential health and safety hazards immediately and don't need to wait for an inspection team or an injury to occur. ([CCOHS](#)) That guidance captures the heart of near-miss reporting. The employer doesn't need to wait until someone is hurt. In fact, waiting until someone is hurt is exactly what a prevention-based safety system is supposed to avoid.

## **Why near-miss systems fail**

Most organizations already have some form of near-miss reporting. The problem is that many systems exist on paper but not in practice. Workers may not report near misses because they believe nothing will happen. They may fear blame, worry about creating trouble for a co-worker, assume the supervisor is too busy, or remember the last time they reported a hazard and never heard back.

Supervisors may unintentionally suppress reporting by treating near misses as interruptions. A supervisor who says, "Are you sure you want to write that up?" has already sent the message. A manager who only asks about production delays, not safety signals, has sent it too. The administrative burden can also weaken reporting. If a near-miss form takes 20 minutes, asks for unnecessary detail, or disappears into a system no one understands, workers will stop using it.

The issue isn't whether the employer has a form. It's whether the employer has trust, response, and follow-through. A reporting system that doesn't produce visible action teaches workers that reporting is symbolic. A reporting system that produces correction teaches workers that their observations matter.

## **Near misses and legal foreseeability**

From a legal standpoint, near-miss data can help or hurt the employer. It helps when the employer can show that workers reported hazards, the employer investigated, corrective actions were assigned, controls were implemented, and the results were reviewed. That's evidence of a functioning prevention system. It hurts when the same hazard appears again and again without meaningful action.

After a serious incident, investigators will look for prior warning signs. Previous near misses involving the same task,

equipment, location, contractor, procedure, or supervisor can establish foreseeability. They show that the employer knew or ought to have known there was a risk. That doesn't automatically mean the employer is liable, but it raises the bar because the employer must explain what it did with the information.

This is why the phrase "we didn't know" is dangerous when the organization had near-miss reports, inspection findings, worker complaints, maintenance requests, or JHSC minutes pointing to the same issue. The more visible the warning signs were, the harder it becomes to defend inaction.

## **The JHSC needs to see the patterns**

In Canadian workplaces, joint health and safety committees and worker health and safety representatives are central to the reporting and prevention system. Near-miss data should not sit only with management or the safety department. The JHSC should see patterns. It should know whether reports are increasing, decreasing, recurring, or clustering around particular tasks. It should review serious near misses and track whether corrective actions are completed.

This doesn't mean every near miss requires a lengthy committee investigation, but the committee should be part of the learning loop. If a warehouse has repeated near misses involving pedestrians and lift trucks, the JHSC should be asking whether traffic routes, mirrors, barriers, speed rules, visibility, lighting, training, and supervision are adequate. If a hospital unit has repeated violence-related near misses, the committee should be examining staffing, flagging systems, panic alarms, care plans, security response, and worker training.

Near-miss data gives the committee something concrete to work with. Without it, the committee is often left reviewing past injuries instead of preventing future ones. That's a missed

opportunity because the internal responsibility system works best when worker participation is tied to current risk, not only historical harm.

## **What good near-miss reporting looks like**

An effective near-miss system is simple enough for workers to use and rigorous enough for management to act on. Workers should be able to report quickly, whether through a mobile form, supervisor intake, paper card, QR code, hotline, or direct communication with a safety representative. The system shouldn't punish detail, but it also shouldn't require workers to write an essay before the organization can start responding.

The system should also classify risk properly because not all near misses are equal. A worker tripping over a loose mat and catching themselves may need a quick housekeeping correction. A worker nearly struck by a suspended load requires immediate escalation. The system should classify events by actual outcome and potential severity, because a no-injury event can still reveal fatal potential.

Serious near misses deserve investigation discipline. That means going beyond "worker wasn't paying attention." Was the procedure unclear? Was production pressure affecting the work? Was the area congested? Was the worker trained? Was the equipment maintained? Was supervision adequate? Were controls missing or poorly designed? Those questions shift the focus from blame to prevention.

Corrective action tracking is where the system becomes real. Every significant near miss should lead to a decision about whether the hazard must be eliminated, substituted, engineered down, managed through stronger administrative controls, addressed through retraining, redesigned, rescheduled, or stopped until controls are adequate. Workers also need feedback. If they don't hear what happened after they

reported, they'll assume the report went nowhere.

## **Weak corrective actions create weak protection**

Near-miss systems often fail at the corrective action stage. The report is filed, a supervisor is notified, and the action says, "reminded employees to be careful." A reminder may be appropriate as part of the response, but it shouldn't be the whole response when the hazard is physical, procedural, or systemic.

If workers are repeatedly slipping on the same icy walkway, the solution isn't simply "use caution." The solution may involve drainage, lighting, sanding, snow removal standards, footwear requirements, inspection frequency, contractor accountability, or temporary closure of the area. If forklifts and pedestrians are nearly colliding, the answer isn't only "watch where you're going." The employer may need painted lanes, physical barriers, speed controls, mirrors, proximity alarms, revised traffic flow, scheduling changes, and supervisor enforcement.

Near-miss reporting only becomes a legal shield when the response is proportionate to the risk. Otherwise, the organization may have created a record showing that it knew about the hazard but responded with a weak control.

## **How to improve reporting culture**

A reporting culture is built through repetition. Workers need to see that near-miss reports are welcomed, not punished. They need to see supervisors thank people for reporting, corrective actions completed, and lessons shared without blame. Language also matters. Calling reports "complaints" can create defensiveness, while calling them "risk signals" or "prevention reports" helps reposition them as operational intelligence.

Leadership behaviour matters even more. If a senior manager celebrates a milestone of “zero reports,” they may be celebrating silence. A better question is whether the organization is seeing the level of reporting it would expect for the risk profile of the work. In a high-hazard environment, no near misses may mean no trust. It may mean workers have learned that reporting creates problems rather than solutions.

Near-miss reporting becomes powerful when the employer trends the data over time. The organization should look for repeat locations, repeat tasks, repeat timing, repeat controls, and repeat causes. Are events clustering in one loading bay, production line, stairwell, unit, route, or worksite? Are close calls more common during shift change, overtime, night work, seasonal peaks, shutdowns, or new-worker onboarding? Are guards being bypassed, procedures skipped, inspections repeated, or staffing and fatigue showing up as recurring contributors? That’s how near-miss reporting becomes predictive.

## **The legal shield is built before the incident**

The best near-miss systems protect workers first. That’s the purpose. But they also protect the organization by creating evidence of prevention. They show that the employer had a reporting mechanism, encouraged worker participation, investigated serious events, involved the JHSC or representative where appropriate, corrected hazards, and verified results.

The opposite is also true. A neglected near-miss system can become a liability record. It can show repeated warnings, weak action, poor supervision, and management knowledge of unresolved risk. That’s the choice Canadian employers face. Near-miss reporting is either an early warning system or a

future evidence file. The difference is whether the employer acts.