

SSIP – Surprise Safety Inspection Programme 2015 Q2 & 3

Here is the footage from

“Site Safety Seminar for Capital Works New Works Contracts” organised by Hong Kong Housing Authority on 28 October 2015.

The speaker is Mr Henry Cheung,

Senior Consultant of the Occupational Safety & Health Council (OSHC),

His presentation topic is

Surprise Safety Inspection Programme (SSIP) – Findings in Q2 and Q3 of 2015 and the Latest Progress of Developing the Housing Authority Occupational Injury and Disease Surveillance System (OIDSS).

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Good afternoon. It’s good to see you again at the Housing Authority Site Safety Seminar.

I will report on what needs to be improved based on the SSIP findings in Q2 and Q3 of 2015.

Let’s talk about the good points here.

The scores you see on the right are median scores.

They cover the SSIP scores of all sites.

The scores of Q3 are on the far right.

To their left are those of Q2.

In Q2, we inspected 42 sites.

The median score is 90.

94 and 86 are the upper and lower quartiles.

98 and 76 are the extreme scores.

In Q3, the scores fell slightly.

The median score is one point lower.

Let’s talk about the good points first.

In Q2 of this year,

Good practices were observed in the provision of designated storage areas for lifting gears,

Installation of RFID detection system for lifting appliances

and proper protection for the projecting bars.

In Q3, we observed provisions of inspection forms for elevating working platforms, reminders for workers using man carrying cages, secure covers for floor openings, etc.

Let's look at the photos.

These are the designated storage areas for lifting gears.

Operation tips were posted in some of the areas.

Crane pads and chains were properly placed for workers' use.

This is the RFID detection system.

If there are workers near the rear of the lifting equipment, the system can detect them.

As Mr Fong mentioned earlier, apart from hooks,

more lifting equipment was available for moving special objects.

We didn't see any worker using this, but we believe this was for lifting H-shaped beams.

This is a clamp hook.

Chains have their limitations.

The projecting bars were properly protected.

The safe working load for the electrical chain block was clearly displayed in Chinese and English.

Step platforms are now more common.

They were properly maintained with all the necessary equipment.

This one had protective railings.

As you know, there is no statutory form for mobile elevating working platforms.

So more sites are creating their own forms for carrying out inspection, such as Form 1.

We approve of that,

but if you are using forms, be sure to fill in all the information, such as the post and title of the person signing the form and the date.

There was clear signage reminding workers to wear safety harnesses when using the man carrying cage.

This is very good.

Secure covers were provided for floor openings.

My colleagues told me this one was quite sturdy.

The metal plate was welded

onto the opening to cover it temporarily and provide protection.

There was also a warning notice.

The safe working load of this fabric sling was clearly marked.

Other than writing the safe working load on the sling with a marker, this is a good method.

I will talk about the Root Cause Analysis of HAOIDSS.

We have been doing this for a period of time.

There are three parts,  
and this is the third part.

We are now testing Part 1 and Part 2.

Some sections have been completed.

We can let you try inputting data in December.

The official launch date will be announced later.

I'll talk about Part 3 - the Root Cause Analysis.

This is a part of the OIDS.

It is not mandatory.

We are only providing a tool that you can choose to use.

We hope that with this tool,  
you can find out the root causes of accidents.

And it will help you fill in the Form F7867 correctly.

This part is divided into three sections.

The first section covers background information of the accident,  
such as the time, cause and persons involved.

The second section is the Accident Analysis.

We refer to the modified "Human Factors Analysis and Classification System" from the United States.

We asked a professor from the Hong Kong Polytechnic University to perform an analysis in 2014

with this tool.

We used the term "modified"

because we increased the number of factors from 19 to 20.

Then there is the Risk Control Action Plan,  
with seven questions for you to answer.

This is mainly for your reference.

You can decide whether you would like to fill in the information or not.

After you have logged in -

you should have created and saved a Form 787,

you can start using this tool.

You will see this screen.

If you need to fill in a Form 787,  
you will see “Root Cause Analysis” in the bottom right corner.  
Click the link and you will be taken to this page.

There is a “Worked Example” on the first page  
for your reference.

When I designed this, I referred to several real life incidents.  
One of them was an accident involving a lorry-mounted crane,  
like the accident that happened yesterday.  
It involves a crane operator and a rigger.  
The rigger is injured because of the operator,  
just like the accident yesterday.

It shows you how to fill in the form.

Apart from filling in the form, there are also some factors.

There are 20 factors based on  
the modified model.

There is an “explanation” for the factors.

For example, you can find out what “skilled based errors” refers to in the  
“explanation”.

It can be technical error or forgetfulness.

It’s in Q&A format.

As I mentioned, the first section is background information,  
when and where the person is injured,  
and whether agents are involved?

It may be a lorry-mounted crane.

What is it doing? Perhaps the crane is in operation.

The first page collects this kind of information.

You don’t have to fill in everything,  
because most information should have been provided in the Form 787,  
and you will see the information in the Root Cause Analysis.

You can add more information,  
or modify incorrect information.

This information has been captured from the Form 787.

The second section is Accident Analysis.

You are required to answer Yes/No questions. These are not easy to answer.

There are text boxes for you to insert answers.

You will see icons providing examples and explanation.

You need to consider whether these factors are directly relevant to the accident.,  
Through an assessment,

Assessing whether the factors are directly relevant.

For example, does the accident involve a skill-based error?

Red means “relevant”,

and the performance of this factor is not good.

Yellow means “abnormal condition but not directly related to the accident”.

Green means “normal condition” and totally irrelevant.

For example, the worker has put on adequate personal protective equipment while operating the lifting gears, so the condition is normal.

“Not applicable” means the factor is truly irrelevant to the accident.

So, red, yellow, green and blue.

If you press this icon, an explanation will be shown.

What does “decision error” refer to?

There will be textual illustration.

If you have missed certain information,

you will be alerted. For example, you have not answered Question No. 3, No. 4 and No. 7.

After you have answered the twenty plus questions ,  
actually there are only 19 questions,  
a four-layer relationship chart will be displayed,  
indicating different directions.

At the bottom layer is “Unsafe Acts”.

In this example, one factor under “Unsafe Acts” is relevant.

It is shown in red.

That’s the skill-based errors.

This accident is directly related to skill-based areas.

The middle layer is “Preconditions”

What condition has resulted in the accident?

Is it the weather, or inadequate maintenance of equipment?

In this example, four factors are relevant.

Green means OK.

Yellow indicates there is room for improvement,  
but the factor is not related to the case.

The top layer is “Supervision”.

Is there adequate supervision?

The top layer refers to organisational resources.

Are there enough resources and arrangements in the organisation?

The colours red, yellow, blue and green are input by you.

This is not an artificial intelligent system,  
so the computer won't know if you have input  
incorrect information.

We rely on you to provide accurate information.

The Cheese Model will be displayed.

Although we anticipate there are holes on the cheese,  
red is seen on every layer,.

So lead to leading dangerous energy shooting directly to the source;?

According to the experts, this may not necessarily be the case.

Some accidents are totally unrelated to frontline workers.

Accidents can still happen.

Please pay attention, it is probably not all red,  
but you will definitely see some red.

If there is no red, the accident will be hard to explain.

Then it is the Section 3, the Risk Control Action Plan.

What do you need to fill in?

Are there risks that need to be reassessed?

Are there operation procedures that need to be reviewed? Or added?

The information should be filled in here,

also the completion date,

and whether anyone is accountable for the accident.

After you have finished filling in the information, of course you should save it.

Or you can download it.

You can also review your form 787.

If the information here is very different from that on the Form 787,  
you need to change the information.

After the analysis,

you may realise the Form 787 has been completed roughly.

There are many things that haven't been considered.

Because in the 20 or so questions here,

we have added a lot of information,

such as the worker's mental status,

and the organisation climate.

In the worked example,

the worker had taken flu medicine,

but he was scared to tell his foreman.

In this site, they don't like trouble.

This can be a cause of the accident.

Firstly, it's not clear whether the medicine caused dizziness.

The worker took medicine he found at home.

This is a problem.

The other problem was that he didn't dare tell his foreman.

In our worked example, we deliberately chose two persons, the crane operator and the injured worker.

Unusually, the protagonist of each case is the injured worker.

But when filling in the information,

it is important to include the status of the other main character, namely the operator.

However, the cheese model you saw just now

has been designed with the injured person in mind.

So we added the 20th factor:

is the accident caused by someone else?

In our worked example,

the operator mistook right for left,

and hit the injured worker with the crane.

Therefore, when filling the information,

you can include everyone involved,

but the injured person is the protagonist of the cheese model.

Let me remind you that,

the effectiveness of any questionnaire or tool

depends on the accuracy and integrity of the data,

whether the information has been filled in honestly.

The software is not artificial intelligence.

We rely on you to fill in the information honestly.

We will be very happy if you are willing to use it.

But if you aren't, there is really nothing we can do.

Let me give you another example.

This is a simple accident.

A worker was injured

while moving concrete.

“Others” was selected for all items, “improper handling”,

“do not use subsidiary tools”.

“Carelessness” was put down for the worker-related factor.

“Others” was selected for factors.

Firstly, it can't all be “Others”.

It is impossible that

the Form 787 cannot even take care of such a simple accident.

If you are not filling in the Form 787 conscientiously, the Root Cause Analysis is basically useless.

Our ultimate goal is to encourage you to be more open minded, and look into more areas in order to prevent similar accidents in future.

We owe it to the workers.

They should not be risking their lives at work.

As occupational safety professionals and site management executives, are we obliged to ensure the safety of workers?

In case of an accident, should we earnestly look for areas of improvement on site and change for improvement?

This should not just be about submitting the Form 787 to meet the HA's requirement.

That's all for my presentation. Thanks.