

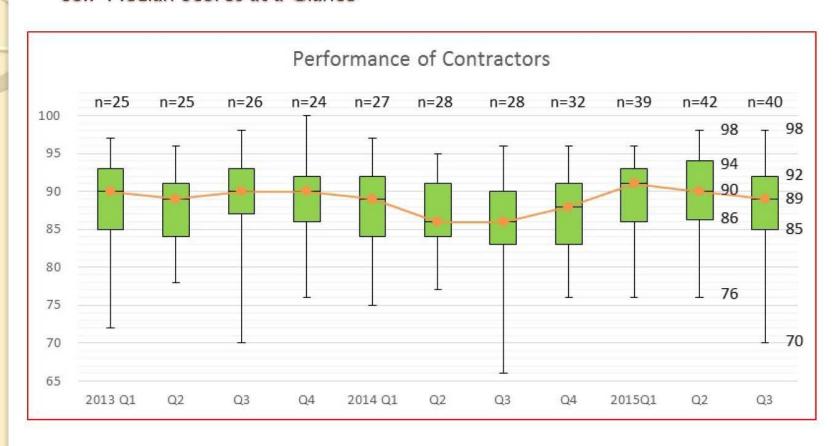
Housing Authority Surprise Safety Inspection Programme (SSIP) Good & Bad Practices 香港房屋委員會 突擊安全巡查計劃



Q2 & 3 2015 良好及不良作業

得分一覽

SSIP Median Scores at a Glance





Summary of Good Practices 良好作業摘要

- Good practices were observed in the provision of designated storage area of LG accessories with proper monitoring guideline, RFID detection for lifting appliance; proper protection for the projecting bolts.
- Good practices: were observed in the provisions of inspection form for mobile elevating working platform, clear signage to remind worker to wear safety harness when using man carrying cage, secure cover for floor openings, and SWL tag for fabric sling.
- 良好作業包括:提供指定起 重裝置儲存區;起重機械機 尾加設RFID 探測系統;為 凸出之鐵支提供適當的保護。
- 良好作業包括:為流動升降 台提供合檢查表格、吊人籠 有清楚標示提醒在內工友必 須佩帶安全帶、為地台缺口 提供穩固保護、纖維吊索有 清楚顯示安全操作負荷。

指定起重裝置儲存區

Designated storage area of LG accessories with proper monitoring guideline





起重機械機尾加設RFID 探測系統 RFID detection of surrounding worker for lifting appliance.





吊運鑽筒時使用正確的起重裝置

Suitable lifting gear for lifting the bored pile casing with valid certificate form 6 and 7.





為凸出之鐵支提供適當的保護

Provision of proper protection for the projecting bolts.





以中英文清晰標示電動鏈條滑車之安全操作負操。 Display SWL in Chinese and English clearly for electrical chain block.







提供梯台以便進行高處工作。

Provide step platform for working at height operations.





為流動升降台提供合檢查表格 Inspection form for mobile elevating working platform.

無权人结构 (94)	REPOR	is Undertaining (Catho, Appliance) and Litting Cost) if TS OF RESULTS OF WEEKLY INSPECTIONS OF LIFTING APPLIANCES.	
Address of installation 18.95% Car Kale final Traces Street	Fig. control and A	A, a, Carectana por Larino de las proposes d'implantes l'Aleile papielle (Carectana e l'Aleile Aleilean ant Limp Care) Aleilean (1)	ren Projektivalni (1815 W)
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吊人籠有清楚標示提醒在內工友必須佩帶安全帶。

Clear signage to remind worker to wear safety harness when using man carrying cage





為地台缺口提供穩固保護



纖維吊索有清楚顯示安全操作負荷 SWL was clearly marked for fabric sling.



2015 Q3

Summary of Bad Practices 不良作業摘要

- Improvements are needed in fulfilling legal requirements of proper working platforms, edge protection, safe means of access and egress, safe use of ladder; toeboards, floor opening cover, proper wearing of safety harness, proper lifeline anchorage, helmet worn with chin strap; material storage, projecting nails and sharp objects removed, passageway kept clear; lifting safety, complete statutory forms; electrical supply system etc.



END 完



28 Oct 2015





- The main function of this part is to assist HAOIDSS users in finding out the root cause of the accident / incident
- Analytical model: Modified Human Factors Analysis and Classification System (HFACS)
- This part is divided into three sections:
 - I. Background Information of the Accident / Incident (4 questions, data retrieved from F-787)
 - 2. Accident / Incident Analysis (with reference to modified HFACS model) (4 layers, 19 questions)
 - 3. Risk Control Action Plan (7 questions)
- Reference: HSG 245 (http://www.hse.gov.uk/pubns/hsg245.pdf)





Login procedures:

- I. Login as Contractor
- 2. Create and Save a 787 form
- 3. Click "Root Cause Analysis"

Forms 787

Case Number	Contract Number	Contract Title	Contractor	Site Staff	Contract Manager	Status	Submission Date	Accident / Incident Date	SIS Number	
2015-00067	4	t4	Anonymous Bright Construction Company Limited	pos2	pos1	Creating	7	2015-09-17		Details PDF Form2





Questions Example

Part 1 - Background Information of the Accident / Incident (Worked example)

1 Where and when did the accident / incident hannen?

By clicking or placing the curser onto this link, an example with explanation and instructions will be shown (as pdf file)

Question	Factor	Explanation
Example:	Skill-based errors	Skill-based errors are unintended behaviors due to attent
 Was there an unintended behavior due to attention failure, technique error, memory failure? No O Yes If yes, briefly explain the situation. 	or	failure, technique error, and memory failure. Skill-base errors consist of slips and lapses. Slips of action are wrong carrying out of a task in terms of time, sequent direction, intensity, calculation, and identification. Laps are the forgetting to carry out an action.
The worker used a mobile working platform (MWP) to paint the external wall of the building. The wheels of MWP were not properly locked prior to use.		





Part I – Background information of the accident / incident

Part 1 - Background Information of the Accident / Incident (Worked example)

Where and when did the accident / incident happen? (Refer to DCMP – F787 Parts G(a), G(b) and G(c))	
The accident happened on Friday, 12 Jun 2015, at 10:11 Al	M.
Who was injured / suffered / involved with the accident / incid(Refer to DCMP – F787 Parts F(b), F(c), I(a), I(b) and I(c))	dent?
Ng Hoi Sum, 30 years old, with 10 years relevant experience	ce, 6 mandays of the injured had been working on site up to the date of this jured. The injury affected his trunk (including chest, abdomen, pelvis, waist)
What activities were being carried out at the time of accident (Refer to DCMP – F787 Part G(d))	t / incident?
Tunnelling	Data retrieved from F-787 and will be filled in
	Data retrieved from F-787 and will be filled in automatically by the system, but the users could
Tunnelling What agent and / or machinery were involved?	
Tunnelling What agent and / or machinery were involved? (Refer to DCMP – F787 Parts G(h), G(i), and K) The agent involved:	automatically by the system, but the users could
Tunnelling What agent and / or machinery were involved? (Refer to DCMP – F787 Parts G(h), G(i), and K) The agent involved: Stored materials Description of the agent involved:	automatically by the system, but the users could
Tunnelling What agent and / or machinery were involved? (Refer to DCMP – F787 Parts G(h), G(i), and K) The agent involved: Stored materials Description of the agent involved: the soil How did the accident/incident happen?	automatically by the system, but the users could have further modification on this part
What agent and / or machinery were involved? (Refer to DCMP – F787 Parts G(h), G(i), and K) The agent involved: Stored materials Description of the agent involved: the soil How did the accident/incident happen? (Refer to DCMP – F787 Parts G(i) and G(j))	automatically by the system, but the users could have further modification on this part





Section 2 – Accident / Incident analysis

- 19 questions will be included in this part, each question has the following functions:
 - 1. "Yes / No" option
 - 2. A text box for inserting answer
 - 3. An icon "?" after each question: A box will be poped up for interpretation with example
 - 4. 4 colors for each questions to be selected:

Relevant to the accident / incident
Abnormal condition but not directly related to the accident / incident
Normal condition
Not applicable





Layer 1 - Unsafe Acts 6. Was it an unintentional behaviour due to attention failure, technique error, or memory failure? <-(click to see the explanation) (Refer to DCMP - F787 Part H(a)) □ No Yes Relevant to the accident / incident Abnormal condition but not directly related to the accident / incident Normal condition Not applicable Briefly explain the situation Decision errors are mistakes in which actions of the individual The removal of the lifting gear from when the crane hook slewed tow proceed as intended and yet the chosen plan proves selecting the slewing direction of inadequate to achieve the desired end state. For unfamiliar tasks, the plans of actions are typically inadequate in terms of what and how should be done, where the action can occur, 7. Did the action(s) of the person proand who should act. Decision errors consist of rule-based (Refer to DCMP - F787 Part H(a)) mistakes, knowledge-based mistakes, and problem solving ☑ No ☐ Yes errors. Rule-based mistakes occur when the behaviour is Relevant to the accident / inc based on remembered rules or familiar procedures. Abnormal condition but not di Knowledge-based mistakes happen when reasoning replies on Normal condition Not applicable "experience" instead of reliable instrumentation, or when one is Briefly explain the situation inexperienced, or is lack of information. Problem-solving errors The plan of action that I/P follow take place when a problem is not well understood, and formal procedures and response options are not available. 8. Was there a perceptual error? (Refer to DCMP - F787 Part H(a)) No Yes Relevant to the accident / incident



A pop-up box will be shown for interpretation with example





Preview of Parts I and 2 questions

medical conditions. Yet, 1/P did not report in the morning of the accident day. The latest SCI score of the factor — Safety promotion and communication" is 59.6 against the overall score of 61.4 reflecting room for improvement in this area.

- 24. Was the organization implementing a comprehensive safety management system?
 (Refer to DCMP F787 Part H(d))
 - No Yes
 - Relevant to the accident / incident
 - Abnormal condition but not directly related to the accident / incident
 - Normal condition
 - Not applicable

Briefly explain the situation.

The organization was implementing a comprehensive <u>SMS</u> with provision of regular internal and external audits. The <u>HASAS</u> audit scores remained high and steady for the last three quarters. However, the management of operators of rented truck-mounted crane (sub-contractor workers) was not adequate. These operators needed not attend induction training and could be left working without site supervision.

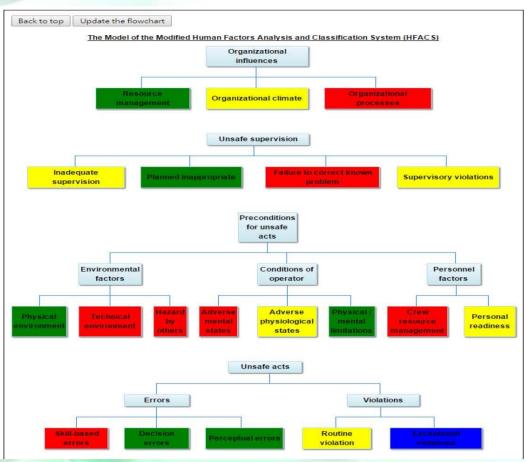
Preview before Submission

If some questions are not yet answered, the questions will be automatically highlighted

Preview of questions in parts I and 2





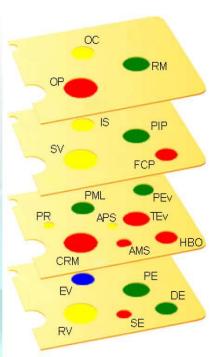


The HFACS model will be displayed at the bottom of the preview page with colors

By clicking onto the box, the system will direct the users back to the respective question for review







Swiss Cheese Model

Layer 4: Organizational influences

- RM Resource management
- · OC Organizational climate
- · OP Organizational processes

Layer 3: Unsafe supervision

- IS Inadequate supervision
- PIP Planned inappropriate
- FCP Failure to correct known problem
- SV Supervisory violations

Layer 2: Preconditions for unsafe acts

Environmental factors

- PEv Physical environment
- TEv Technical environment
- HBO Hazard by others
- Layer 1: Unsafe acts

Errors

- SE Skill-based errors
- . DE Decision errors
- PE Perceptual errors

Conditions of operator

- AMS Adverse mental states
- APS Adverse physiological states
- PML Physical / mental limitations

Violations

- · RV- Routine violation
- . EV Exceptional violations

A cheese model will be displayed for showing their relationship at the bottom of the page

Personnel factors

- CRM Crew resource management
- · PR Personal readiness

Back to top



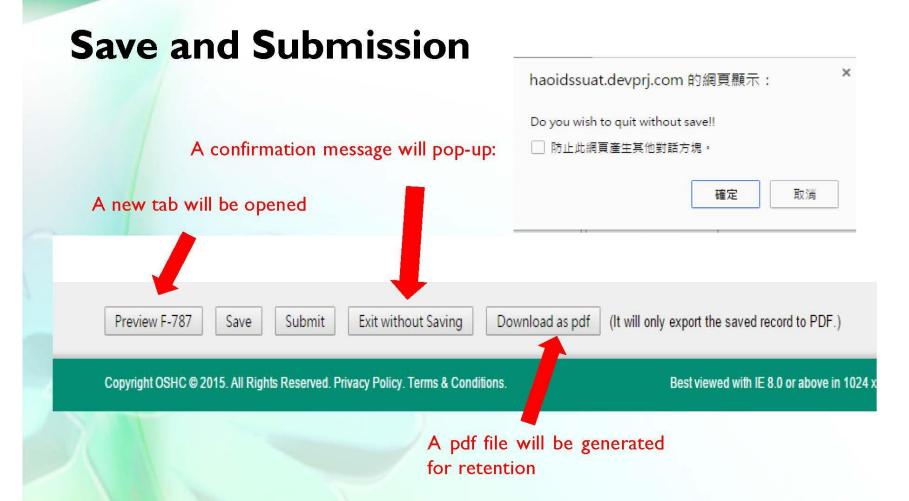
Part 3 - Risk Control Action Plan

Part 3 - Risk Control Action Plan

No similar adverse events have happ	pened before.		
Which risk control measures should be (Refer to DCMP – F787 Parts H(f) and		short term?	
Control measure	Completion Date	Person responsible	
Remind sub-contractor to enhance compliance with the safe lifting procedures.	7 August 2014	Mr LAU Wah (Area Foreman)	
Alert trade supervisors, foremen and workers about the accident through safety meetings and morning briefings.	8 August 2014	Mr Simon Chan (Site Agent)	7 questions to be answered for
assessments and operating	22 August 2014	Mr LAU Wah (Area Foreman) Mr Andrew Cheung (Engineer) Ms Carmen Law (Safety Officer)	
3 procedures.		A A	follow-up actions
6			











The usefulness of the root cause of the accident / incident will be restricted when there are:

- Insufficient data
- Wrong data
- Presence of missing data
- Limited explanation or description





	Ha01 [2000	Failure to warn	Ha02 🗌	to the accident / incident (Tick more the Removing safety devices	Ha03	Improper loading	
	Ha04 [Failure to secure	Ha05 🗆	Using defective equipment	Ha06	Improper lifting	
	Ha07 [Using improper equipment	Ha08	Servicing equipment in operation	Ha09 🗆	Improper position for job	
	Ha10 [Improper placement	Ha11	Under influence of alcohol / drugs	Ha12	Working at improper speed	
	Ha13		Horseplay	Ha14	Making safety devices inoperable	na15 □	Operating without permission	
	Ha16		Failure to use personal	Ha17 🗆	Working on incomplete	42.00 CO. C.	Others (Please Specify):	
			protective equipment		scaffold / work platform	The La	improper handling	
) In	dicate a	ny :	sub-standard conditions which h	ad contribu	ted to the accident / incident (Tick more	e than one box i	f necessary)	d information
	Hb01 [Inadequate guards / barriers	Hb02 □	Defective-tools / equipment	Hb03 □	Congestion	d illioi illadoli
	Hb04 [Unsafe access	Hb05 □	Poor housekeeping	Hb06 □	Inadequate ventilation	
	Hb07 [Lack of guard-rails	Hb08 □	Unsafe footing, slippery ground	Hb09 □	Inadequate / excess lighting	
	Hb10 [Inadequate warning system	Hb11 🗌	Fire and explosive hazards	Hb12 □	Adverse weather	1
	Hb13 []	Inadequate / improper personal	Hb14 🗌	Hazardous environmental	Hb15 □	Damaged scaffold & catch	chould
			protective equipment		conditions (smoke, dust etc.)		fan & nylon mesh	ation Silver
	Hb16 [Inadequate protective canopy	Hb17 □	Working process tampered	Hb18 □	Overloading	formati + and
	Hb19 [Lack of work platform	Hb20 ☑	Others (Please Specify): did	not use subsidia	ry tool (for example trolley)	escient a
								formation should be sufficient and in
In	dicate a	ny	personal factors which had cont	ributed to th	e accident / incident (Tick more than o	ne box if necess	sary)	details!
	Hc01 []	Inadequate ability	Hc02 □	Lack of knowledge	Hc03	Lack of skill	detalls.
	Hc04 [Stress	Hc05 □	Improper motivation	HCU6 🗔	Lack of training	4C
	Hc07 [Tiredness	Hc08 □	Sick	Hc09 □	Lack of communication	
	Hc10 [Underestimation of risk	Hc11 ☑	Others (Please Specify): care	elessness		
	-	200			d to the accident / incident (net more t	The second secon		careless was the I/P?
	Hd01 [35	Inadequate engineering	Hd02 ☑	Inadequate leadership/supervision	Hd03 □	Inadequate maintenance	
	Hd04 [Unrealistic work schedule	Hd05 □	Inadequate tools / equipment	Hd06 □	Wear & tear	
	Hd07 [Inadequate work standards	Hd08 □	Inadequate purchasing / materials	Hd09 □	Inadequate examination of	
	Hd10 [Others (Please Specify):		management		equipment	