SSHSCC/48/B

SUMMARIES ENTERED ONTO HSE'S FOCUS DATABASE SINCE PREVIOUS SSHSCC OF ACCIDENTS AND DANGEROUS OCCURRENCES INVESTIGATED IN SHIP AND BOAT YARDS

SUMMARY

1. This paper introduces the summaries of accidents and dangerous occurrences investigated in ship and boat yards since the 47th SSHSCC. Details are also given of recent prosecution cases involving ship/boat yards.

BACKGROUND

2. At the 40th SSHSCC it was agreed that accident investigation summaries would be distributed with the agendas for the forthcoming meetings.

ACTION

3. Members are asked to:

- note the content of the accident investigation summaries detailed as appendix 1 and to satisfy themselves where relevant, that they have adequate arrangements in place to prevent similar accidents from happening in their yards; and

- note the details of the two prosecution cases involving boat/ship yards that have been heard since the 47th meeting (see appendix 2).

Appendix 1 – Accidents investigated in ship/boat yards 04/03 – 08/03

Fall from height

1. IP broke their arm when they fell from 4th/5th rung of ladder while polishing the hull of a boat in a workshop. A working platform with handrails was available that could have been used instead.

2. IP placed a ladder on scaffold boards supported by two trestles. He was climbing the ladder when he fell to the ground. The ladder was neither tied nor footed as it was only seen as a quick job.

3. IP killed by fall into a dry dock when using a rope to raise a ladder out of the dock. Concerns identified regarding the design and maintenance of the dry dock edge protection.

Confined space

4. Employees were working in a ship's steering flat disconnecting its rudders. As the rudders' couplings were tight, heat was applied to try and loosen them.

An oxy-acetylene blowtorch and then a propane torch were used on and off over a period of 3 hours. All 6 men involved came up onto deck coughing, which did not seem particularly unusual to them. However, the IP's condition worsened at home and they were admitted to hospital due to acute damage to lungs. Immediate cause of the incident was a lack of ventilation in the confined space. Underlying causes include i) a failure to review the risk assessment when the method of work was changed to involve the application of heat; and ii) it was not recognised that introducing a blow torch into the space in which they were working made it into confined space. Corrective action taken includes: i) employees sent on confined space training; ii) increased awareness of the need for ventilation and the requirements of the Confined Spaces Approved Code of Practice; and iii) procedure established for confined space work.

Miscellaneous

5. IP injured his back when lifting a roll of material. This is normally a two-man job however due to restricted space this was not possible.

6. IP was trying to fit a rudder to the boat when the rudder spun round and slipped off its support. As it did so it gave the IP a glancing blow to the right side of his head and his collarbone. Handling arrangements have since been properly assessed and improved control measures put in place. Rudders are now hoisted into position and remain attached to the hoist rope until fitted into position.

7. IP hit his right leg below the knee when he slipped on the deck of a boat.

8. IP used a circular saw to cut into a wooden pole and then used a push stick to clear the resulting offcut away from the blade. The offcut kicked back and impaled his right leg near the groin area. Possible concerns identified regarding training and supervision. Work now undertaken by an alternative method not involving the use of the circular saw.

9. IP developed an allergic reaction to epoxy resin. Concerns identified regarding PPE and COSHH assessment.

Dangerous occurrences

10. Crane failed when the stop button in the cab failed to depower the derricking winch, due to a suspected electrical fault. Both maintenance and statutory inspections had taken place.

11. A rough terrain mobile crane overturned whilst moving across the side of the dock. While a load was not being carried at the time, the very short radius of the jib meant that as it slewed the counterbalance weight caused the crane to overturn backwards. The jib fell against a ship in dock preventing it from falling into the dock. The crane had not undergone a statutory examination and while the crane driver was trained he had not had refresher training since 1995.

Appendix 2 – Prosecution cases brought since the 47th meeting involving ship/boat yards

1. Prosecution under Regulation 5 of the Provision and Use of Work Equipment Regulations 1998 and Regulation 9 of the Lifting Operations and Lifting Equipment Regulations 1998 in relation to a failure to i) have a crane thoroughly examined by a competent person; and ii) to maintain the crane in a state of good repair. Fines totaling £500 and costs of £748.

2. Prosecution under Section 2(1) of the Health and Safety at Work etc Act 1974 in relation to an accident to an employee who suffered part amputation of two fingers whilst operating an unguarded pillar drilling machine while wearing a glove. Fine of £5000 and costs of £1365