

**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 48th SSHSCC.

**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

**Appendix 1 – Accidents investigated in ship/boat yards 08/03 – 11/03**

Fall from height

1. 3 men, including the IP moved a boat. A portable ladder was replaced after but not re-tied. The IP climbed the ladder when alone and fell approximately 2 m from the ladder. The IP suffered a dislocated elbow and suffered 2 fractures of the lower arm and was expected to be off work 6 months. The ladder was set on gravel. Weather conditions were fine and dry and the IP was wearing safety shoes. No tools were carried up the ladder. No training had been given in ladder safety. An Improvement Notice was issued

Workplace transport

2. A trained fork lift truck driver operated the vehicle whilst outside the cab standing on factory floor and drove it over his right foot in process breaking bones when the edge of the steel toe of the safety boot being worn dug into the foot. The IP had been driving FLT's for 9 year; had been trained and had refresher training 3 years before. The need for supervision was emphasized as the IP admitted to d moving a FLT in this manner in the past.

Miscellaneous

3. IP was in the process of machining a part on a slotting machine. The tool shattered on the first cut after being changed and a piece went into the IP's eye. Fortunately, there was no lasting damage to the eye. IP confirmed

having been issued with safety glasses and that there were notices displayed around the machine.

4. IP was using a Robinson hand fed planing machine to edge a piece of Formica material approximately 25cmx10cmx5mm. The IP held the material along its long edge and was machining the opposite edge. IP's hand slipped and left ring finger came into contact with the blade resulting in amputation above the knuckle. The machine was fitted with a suitable bridge guard but was being operated with the fence approximately 20 cm from the table edge and the guard was not covering any of the blade. IP is a trained joiner and machinist and has been operating similar machines for 15 years. The IP was aware of the correct setting for the guards but failed to adjust these.

#### **Appendix 2 – Prosecution cases brought since the 47<sup>th</sup> meeting involving ship/boat yards**

There have been no completed prosecutions involving ship/boat yards since the last meeting.