

**MINUTES OF THE FOURTY-FOURTH MEETING OF THE SHIPBUILDING AND SHIP-REPAIRING HEALTH AND SAFETY CONSULTATIVE COMMITTEE ON 17<sup>TH</sup> APRIL 2002 AT BAE SYATEMS (MARINE) LTD, GLASGOW**

**PRESENT**

Mr Jim Picksley, *BAE SYSTEMS (Marine) Ltd/GMB*  
Mr Pete Harding, *Vosper Thornycroft (UK) Ltd*  
Mr Barry Irvine, *Fleet Support Ltd*  
Mr Nick Granger, *Shipbuilders and Ship-repairers Association*  
Mr J Brown, *George Prior Engineering Ltd*  
Mr Mark Lomas, *Devonport Management Ltd*  
Mr Eddie Paton, *BAE SYSTEMS (Marine) Ltd*  
Ms Kay Nicholson, *BAE SYSTEMS (Marine) Ltd*  
Mr David Allison, *Marine Painting Forum*  
Mr Douglas Thomson, *HMNB Clyde*  
Mr Joe Atkinson, *A & P Tyne Ltd*  
Mr Jon Davies, *BAE SYSTEMS (Marine) Ltd*  
Mr George MacLeod, *Engineering and Marine Training Authority*  
Mr Jeffrey Arkle, *P & K Consultants*  
Mr Willie McLachlan, *BAE SYSTEMS (Marine) Ltd*  
Mr Alan Crawford, *Pyeroy*  
Mr Garry Stimpson, *HSE*  
Mr Michael Stewart *HSE*

Mr Roger Sykes, *HSE*  
Mr Graham Watson, *HSE*  
Miss Gemma Currie, *HSE*

**APOLOGIES**

Mr Nik Parker - *British Marine Industries Federation*  
Mr Don McDonald - *HM Naval Base Portsmouth*  
Mr Graham Morrison - *Warship Support Agency*  
Mr Bill O'Neill - *HSE Northern Ireland*  
Mr Alan Kirkwood - *Semple Cochcrane Plc*  
Mr Bill Steven - *MacDuff Shipyards Ltd*  
Mr Keith Strachan - *Pyeroy Ltd*

**WELCOME**

Members were welcomed to the 44<sup>th</sup> meeting by Ms Kay Nicholson. Mr Eddie Paton gave an informative account of the history of BAE SYSTEMS (Marine) Ltd.

**1. CHAIRPERSONS INTRODUCTION**

Mr Roger Sykes welcomed the members and thanked them for attending. Mr Sykes explained that a replacement for Rosi Edwards is expected to be in

post by the September SSHSCC meeting. Mr Sykes welcomed as a new member, Mr Jeffrey Arkle from P and K Consultants based in County Durham who are representing British Maritime Technology Group Ltd. Mr Arkle had previously been a member of the committee when representing the Weir Dockyard. Mr Sykes also welcomed Mr Douglas Thomson who was attending instead of Captain Andrew McFarlane, HM Naval Base Clyde and Mr George McLeod from EMTA who was attending as a temporary stand in for Mr Bill Corteen who has retired. Mr Sykes extended thanks on behalf of the members to Bill for his help over the years. Also welcomed were Mr Alan Crawford who was attending instead of Keith Strachan from Pyeroy Ltd, Mr Michael Stewart HSE Noise and Vibration Specialist Inspector and Mr Garry Stimpson the local HSE inspector responsible for shipbuilding and ship-repair. Members were also introduced to Miss Gemma Currie who has replaced Margaret Simpson as the admin support to the Engineering & Utilities Sector and who will be providing similar support to the SSHSCC. Mr Sykes extended thanks to Margaret for her help in supporting the work of the secretariat.

## **2. APOLOGIES FOR ABSENCE**

Mr Sykes passed on apologies for absence.

## **3. MEMBERSHIP CHANGES**

Mr Sykes gave details of the following changes to the SSHSCC membership: George Craig Group has pulled out of ship-repair and hence will no longer be members of the committee; Alan Lascelles from the Environment Agency has left the agency. Mr Graham Donachie will be the contact until Alan's replacement is in post. Mr Sykes extended his thanks to Alan for his help over the years. Mr Sykes informed members that Martin Plummer had resigned from the SSHSCC and extended his thanks to Martin on behalf of the members for all his help and support. Northwestern Shiprepairers and Shipbuilders Ltd who have taken over the Bidston dry dock at Birkenhead have joined the committee. The contact is Mr Mike Moran, General Manager and Director.

## **4. MINUTES OF THE LAST MEETING**

Members agreed the minutes following the correction of a couple of minor errors.

## **5. MATTERS ARISING**

(a) Minute item 4a – Olivine

At the last meeting Mr. Watson had informed members that the suppliers of olivine had agreed to voluntarily prohibit the supply of olivine for dry blasting due to concerns regarding possible asbestos contamination. The prohibition was due to come into effect from February 2002; Mr Watson confirmed that the prohibition was now in place. The prohibition did not however, apply to the use of olivine for wet blasting and would stay in place until the suppliers of

the olivine can satisfactorily demonstrate that the olivine is asbestos free. Mr. Allison commented that the extent of the contamination was controversial.

(b) Minute item 4b – Ultra High Pressure Water Jetting

Mr. Watson provided members with additional details of the 'Turtleskin Waterarmor' protective equipment suitable for use with high pressure, water-jetting equipment. It was emphasised that HSE was not recommending this particular make of protective equipment over another but merely making members aware that this type of equipment was now available. It is intended that the Sector Information Minute (SIM) advising on this issue and circulated at a previous meeting will be issued on 24<sup>th</sup> May. Mr Watson undertook to distribute a copy of the SIM at the next meeting.

Action: Mr Watson

(c) Minute item 15 – News update

Mr Watson agreed at the last meeting to check how long Enforcement Notices will remain on the Notices Database on HSE's web site. He informed members that they would remain there for 10 years.

## **6. FATAL ACCIDENT INQUIRY**

Mr. Watson presented paper 44/A highlighting the main issues raised by the fatal accident report on the Glomar Artic double fatality. The accident involved hot work in a confined space during which a build up of propane, which had leaked from a damaged hose, was ignited. It was emphasised that whilst the accident had happened on an offshore rig the work that was being done, and the circumstances of the accident were equally relevant to work undertaken in shipyards. Members were therefore advised that it was essential for them to take onboard the lessons to be learnt from the incident to ensure that a similar event cannot happen in their yards. Mr Watson stated that this was particularly important, as many of the factors that led up to the accident have previously been identified as contributory factors in accidents in shipyards. The sole difference being that such factors have occurred in different yards and at different times, whereas in the Glomar Artic incident they all came together at the same time.

Examples of similar failings in shipyards provided by Mr Watson included, in relation to management/supervision, accidents where over reliance has been placed on the skills and experience of the workforce and a corresponding lack of management control. Accidents have also occurred where employees have failed to follow company procedures and where there has been poor communication with contractors and between groups of employees. Concerns with risk assessments, similar to those identified in the Glomar Artic incident have also been identified in relation to accidents in shipyards. These have included risk assessments, which have been generic and have failed to record exact details of how risks may occur. Accidents have also occurred where

despite the high risk nature of the work a risk assessment or a method statement were not undertaken.

In relation to work in confined spaces a very similar incident has already occurred in a shipyard. This involved a fabricator who received burns to his legs when using an oxy-propane torch in a semi-confined space. His torch ignited a build up of propane in a floor compartment. He had just started work; the torch had last been used an hour ago when the previous worker had not turned off the gas supply properly. Contributory factors included various failures by the subcontractor to follow site rules and overall poor control of contractors.

With regards to concerns regarding means of access/egress identified by the fatal accident inquiry, Mr Watson stated that members themselves have already identified this as an issue in shipyards owing to the small size of some manholes. In relation to concerns identified regarding the workforce similar concerns have again also been identified following accidents in shipyards. Examples of this include accidents where there has been a lack of knowledge of safe procedures amongst apparently trained operatives and where trained and experienced employees have failed to follow safe procedures. The Glomar Artic incident involved a propane hose becoming damaged, this has also happened in a shipyard accident whereby a burner's fuel pipes dropped to the bottom of the work area where they were set alight by slag.

Mr Watson again emphasised that given the potential for a similar incident to happen in a shipyard it was essential that members looked long and hard at each of the issues involved in the Glomar Artic incident to make sure that they are taking all necessary precautions in their yards. In relation to *management/supervision* members were asked: How confident are they that their foremen/chargehands are adequately trained in, and fully aware of their health and safety responsibilities? What had they done to ensure that this was the case? What action do they take to try and ensure that their contractors' managers, foremen/chargehands are fully aware of their health and safety responsibilities? How sure are they that the procedures in their health and safety manuals are followed? What steps do they take to ensure that this is the case?

Mr Lomas stated that they had reassessed and reissued their health and safety arrangements, which involved providing training and following a structured approach. This was the first occasion that when a new or substantially changed procedure has been developed that training has been provided. Normally they would be sent out electronically with a hyperlink. However, Mr Lomas felt that any organisation, which expects an overworked supervisor to click on the hyperlink and identify the training needs, was misguided. Nobody should be expected to follow procedures unless they have had training on it.

Mr Paton explained that a management system can be fairly comprehensive containing a lot of information. To get round this they summarised their management system creating a safety plan, which was backed up by monthly

safety inspections. A list was produced for the inspections detailing what the main things were that had to be done, this included reference to hot work.

Mr Sykes felt it was easy to underestimate what is involved however; the Glomar Artic incident illustrates what can go wrong and highlights the need to manage the risk.

Mr Allison observed that often in the past no matter what was written down people basically did something else. This illustrated why those at the top had to ask questions to make sure that people were doing what they ought. Mr Sykes agreed that there had to be the commitment from management.

With regards to *risk assessments* Mr Watson asked members: Did they do risk assessments of high hazard work undertaken by their contractors? If not, how did they know what health and safety requirements to include in the contract? Did members verify the adequacy of their contractors' risk assessments? If members used generic risk assessments, how confident were they that for high risk work all the risks specific to that work were identified? How did members make sure that the main findings of the assessments were brought to the attention of all relevant employees?

Mr Harding confirmed that they required their contractors to do their own risk assessments although they check their adequacy. Mr Sykes referred to the Associated Octel case as an example of what people are expected to do. As a minimum they should verify their contractors' risk assessments are adequate and if not they should ask for them to be improved. Mr Lomas stated that they hold up a job until a site specific and task specific risk assessment are in place. He said that generic method statements were endemic in construction; they included for example reference to trees etc. in connection with work in shipyards. Unless the contractor has a site specific and a task specific assessment he felt you could not assess their competency to do the risk assessment.

Mr Harding explained that they involved employee representatives in doing risk assessments, which was a good way of ensuring that employees were aware of the content of the risk assessment. They also go into a work area and ask employees questions to see if they are aware of a particular risk assessment, which was a good way of checking that risk assessments are getting through. Mr Picksley said it was fundamental to get employees involved at the start of a process and to make sure they are aware of the risks before the work begins.

Mr Lomas explained that the precautions they take depend on the hazards involved and the experience of the employee. If it is high risk work and the person involved is inexperienced they will seek confirmation that they have been trained in the risk assessment. On the other end of the scale if the work is low risk and the worker is experienced all they will do is check that a copy of the risk assessment is available. There was he felt, a reluctance by some employees to sign to say that they have been briefed on a risk assessment as they are concerned about possible fall back should something go wrong. It

was also now compulsory for their safety representatives to be involved in preparing original risk assessments. Initially their attendance was voluntary, managers chose not to involve them. It was however crucial to involve the people who are doing the work, as they know what is done and what is practical. Mr Lomas also referred to when Babcock Engineering involved a couple of consultants in preparing risk assessments. Accidents continued to rise as the risk assessment stayed in the folder.

Mr McLachlan said that they had got risk assessments down to a single page by addressing key hazards in a line each. If people needed more information the risk assessment tells them where to find it. The assessments are all available in files at all the safety points and they have proved to be quite successful.

Mr Picksley stated that they used to have “Kit for the job” cards, which were successful. They were primarily based on COSHH assessments and told you what gear you had to wear. However, they were a lot of work and managers allowed it to fall by the wayside. Mr McLachlan confirmed that it was essential to get management commitment and backing especially if a procedure is to reduce accidents. You have to show managers that it is working and to sell it to them. Mr Sykes identified however that was a problem in that a procedure may work one day and not the next. We are all human and have human failings that we need to be aware of.

Mr Watson asked members if they verified the competence of their employees and contractors’ employees, to *work in confined spaces*. Members were also asked if welding hoses were checked in their yards prior to use and if so, how could they be sure of this? As the Glomar Artic incident happened after the welding hoses had been left in the confined space for just half an hour members were asked if in their yards, hoses were removed from confined spaces as necessary. They were also asked whether it would be possible to introduce a system by which welding hoses are only “live” when needed.

Mr Paton informed the members that they had just introduced a system which addresses the competence of employees and contractors and which includes monitoring and rescue arrangements. The training started off with management and was continued right through the organisation involving all trades who do confined space work.

Mr Allison stated that recently a subcontracting firm had provided him with a very comprehensive confined space procedure. However, one of his concerns with this type of work has been confirmed and that is that despite arrangements being in place in theory, people often do not do what they are meant to do. He was not sure what the answer was although he felt that managers had to improve the culture and the collaboration of employees. Mr Paton said it all came back to management procedure, health and safety risk assessments etc. all need to be interlinked as no system or procedure can stand on its own. Mr Sykes stated that each yard is different and that there was not a single answer. The fatal accident report draws out the key issues; members need to ask questions of their own yards particularly as the report

clearly indicates that the lessons of Piper Alpha have not been learnt. Mr Allison said he was particularly disappointed reading the report given the previous incident of a similar nature in the early 1970s when bottles of gas were left onboard a ship overnight. Lessons were apparently learnt then but here we go again.

Mr Sykes mentioned that while the Glomar Artic accident involved a different industry, there was a need to ensure that in the shipbuilding/repair industries and other industries that lessons are learnt.

Mr Lomas said that he had some experience of offshore work and that some managers had difficulties in appreciating the concept of confined space work. They tended to associate confined spaces just with restricted spaces and not restricted physical space plus additional work as they failed to see that it extended beyond just a physical issue. Mr Allison referred to the SSA Confined Space guidance, which states that whether a confined space is a confined space or not depends on what is done in that space. However, he felt that this was a difficult concept for some people and he was not sure of the way round it. Mr Sykes replied that perhaps the solution was to discuss the issue on a one-to-one basis and to explain that a space could be fine until work was introduced into it. He was though unsure how to get this across on paper, they had tried with the SSA Guidance and perhaps this needed to be reviewed.

## **7. CONFINED SPACE RESCUE PROCEDURES**

The issue of confined space emergency rescue arrangements was raised by Mr Allison and included in the discussion of the fatal accident report. Mr Allison was concerned that different yards have different procedures, some require contractors to provide emergency response teams, given the diverse range of requirements it was not always clear who was to do what. Mr Watson referred to the Confined Space Approved Code of Practice, which states that where employers or the self-employed have duties in relation to people who are not their employees then the duty is to do what is “reasonably practicable” in the circumstances. In many cases the employer will need to liaise and co-operate with other employers to agree the respective responsibilities in terms of the regulations and duties.

Mr Stimpson referred to his own experience in West Scotland where yards often rely on the fire brigade to deal with confined space rescues. He approached the Fire Services who advised him that they are not financed to rescue people from confined spaces. Strathclyde Fire Brigade said that they would have a go at rescue while Tayside Fire Brigade said they would only remove the deceased. Only the fire services at Naval Bases have the equipment needed for confined space rescue. Yards should not therefore rely on local fire brigades unless they have the right equipment. Mr Stimpson said that he had done a lot of work with the yards to move the issue forward however this involved spending a considerable sum of money.

Mr Brown commented that their local fire brigade practice confined space rescue in their yard and that they had difficulty just getting through the manhole with their fire clothing on. He was also not aware that the fire brigade did not have confined space rescue as part of their formal remit. Mr Sykes also mentioned that it was important to remember that if there was a major incident elsewhere the fire brigade may not be able to respond.

Mr Allison stated that if contractors are told that they need to provide emergency rescue equipment then perhaps there is a need for more collaboration. Contractors need local knowledge in order to get the fire brigade out; they need to come to an agreement with the yard they are working in as to who will provide what. Mr Atkinson mentioned that they will provide a rescue team within set hours, if a contractor works out with these hours they must provide their own rescue procedures and if they do not they cannot do the work.

Mr Paton explained that they have rolled out a confined space rescue procedure. This involves a core team of people who are the rescue team although other people are also essential. This includes crane operators, supervisors etc. who are needed to make sure that the routes are clear and that ambulances know where to go. It is therefore essential not to rely just on the core people; if you rely just on the fire brigade and ignore others the arrangements will fail. Mr Picksley stated that they had a trained core of people for confined space rescue. However, they just dived straight down a hole without first considering the atmosphere in the confined space etc. During an incident the procedure failed and they are now moving away from rescue teams.

Mr Stimpson emphasised that the confined space rescue procedure had to have commitment from management and everybody to make it work. It also needed a lot of effort including refresher training, calibration of equipment all of which requires continuous effort and not just in the first year.

Mr Brown raised concerns about the extraction ducting catching fire and the lack of a standard specific to the fire resistance of ducting. Mr Sykes replied that a satisfactory answer was not reached on this issue when raised at a previous meeting.

The issue of providing an alternative access route into a confined space was discussed. Mr Arkle explained that in the case of ship repair this could cause problems with ship owners. It also involves extra costs in terms of timescales etc. and while it is a difficult issue it is a question that needs to be constantly asked. Mr Picksley also mentioned that in new build the sequence of work can also help.

Members agreed to continue the discussion regarding the fatal accident report at the next meeting when the Sheriff's recommendations would be considered as well as how this issue should be taken forward.

## 8. WHOLE BODY VIBRATION/HAND-ARM VIBRATION

Mr. Stewart, HSE Noise and Vibration Specialist Inspector updated members on the latest position of the Physical Agents Directives with regards to noise, whole body vibration and hand-arm vibration. The Directive dealing with noise was not at the same level of agreement as it was with regards to vibration. There were two main sticking points, the right to audiometry where exposure is above 80 dB(A) and the exemption for the music industry. There are however elements that are not likely to change including the exposure action value of 80 dB(A), which will have the same duties as the existing first action level of 85 dB(A). The second exposure action value of 85 dB (A) is also likely to remain the same, with the same duties as the current second action level of 90 dB(A).

Mr Stewart did not feel that the Whole Body part of the Physical Agents Directive would have much of an impact on the shipbuilding and repair industries particularly when compared to other industries such as agriculture and construction. The activities most relevant to whole body vibration in shipyards are likely to be operating a forklift truck and possibly operating a crane. One of the main health effects of exposure to whole body vibration is low back pain. However, Mr Stewart felt that science was not advanced enough to differentiate back pain caused by exposure to whole body from other causes of back pain. Mr Allison raised the issue of the possible combined effect of exposure to whole body vibration and noise and referred to a possible database concerning this issue. Mr Sykes replied that this had previously been looked into and it was not possible to locate it.

Whole body vibration should be considered as part of an ergonomic assessment. In the case of a forklift truck operator this should also consider whether they twist their body when operating the truck and whether they do manual handling as part of this task. While whole body vibration did not have a dose/effect relationship this does not mean that there was not an issue, lorry drivers for example were more than two and a half times more likely to suffer from low back pain than the normal population. Employers are not though expected to go out and buy a vibration meter to measure exposure to whole body vibration as manufacturers of the equipment should be telling users of their equipment what the vibration levels are likely to be.

Mr Stewart then went onto expand on the overheads distributed at the meeting (copies of which are enclosed for members who were not present at the meeting). Measured data from a HSE Contract research report identified whole body vibration levels of 0.9 to 1.4 m/s<sup>2</sup> for lift trucks. These however were just vibration measurements; the concern of the Directive is with exposure levels. With some lift trucks there could be cause for concern if they are driven around all day. Vibration levels depend on several issues: maintenance of truck, surface levels, the way the truck is driven, whether or not potholes are avoided etc. If exposure levels are high, measures such as anti-vibration seats will need to be considered. However, if such seats are used they need to be adjusted for the correct weight i.e. the driver's weight.

Such seats can be retrofitted to trucks but they need to be properly fitted and used.

Members were also updated on the latest position of the part of the Physical Agents Directive dealing with hand-arm vibration. The European Parliament and the European Council have agreed the Directive including the transitional arrangements. However, the industries in which these arrangements will apply have still to be decided. Members were therefore advised that if they had concerns with this they should make sure that their voice is heard, for example via industry trade associations.

Mr Arkle queried whether people had to buy new tools, which complied with the reduced vibration levels contained in the Directive. Mr Sykes replied that people will need to have tools with vibration levels, which will enable them to comply with the exposure levels. This will be easier with new tools as they tend to have lower vibration levels. The limits set by the Directive apply to the user's exposure and not to the tools' vibration levels. Mr Stewart pointed out that the Directive was only a users' Directive, as it did not place any duties on suppliers. People should therefore ask their tool suppliers for vibration data reflecting actual use and not just declared levels. Mr Sykes mentioned that Information Document (ID) HSE 246/31 is available on this; he suggested that members send a copy of the ID to their suppliers and demand that they provide this information. Mr Sykes undertook to supply members with a copy of the ID (attached).

Members were reminded that BAE SYSTEMS (Marine) Ltd have hand-arm vibration data, which they have previously offered to share and the offer still stands. Mr Allison raised the issue of "blasters" who were previously exposed to HAV and were now using water-jetting equipment, which exposed their hands to low temperatures. Mr Sykes felt people may be exposed to blanching and that they should keep their hands warm for example by rewarming them. Mr Stewart referred to a report on water jetting, which states that due to the high pressures involved the water hose was warm. The report also recommended that people take a break every 20 minutes. Mr Sykes said that as water jetting involved very low levels of vibration he was doubtful that further damage would be caused by its use however, he would seek medical advice on this and report back.

Action: Mr Sykes

Mr Stewart informed members that the HSE publication *Vibration Solutions* HSG 170 (ISBN 0717609545) had been missed off the list of references on his last overhead.

Mr Allison informed members that he had attended a meeting of the Engineering Industry Noise Task Group (EINTG) to represent a wider industry including shot blasting and other painting processes. These processes he felt were significant generators of noise and may have problems in complying with the new noise limits set by the Directive. He believed the EINTG should be disseminating information and guidance to the industry via the SSHSCC. Mr

Allison also did not feel able to lobby European Parliament Members, as he did not have typical exposure data for the industry. Members were asked if they could supply Mr Allison with information on this. Reference was also made to HSE figures, which indicate that a large proportion of people are not doing noise assessments. Mr Allison understood the Directive contained such a requirement and wondered when the HSE would get round to enforcing it. Mr Sykes commented that noise is a priority for HSE along with other issues.

File note: Members wishing the advice of a HSE Noise and Vibration Specialist should not contact Mike Stewart unless they are based in Scotland. Instead members should contact their local HSE Inspector who can then put them in contact with the Noise and Vibration Specialist who covers that area.

## **9. HEALTH AND SAFETY PASSPORT SCHEMES**

Mr. Watson presented paper 44B, which raised the issue of health and safety passports. He explained that HSE saw these as beneficial and was prepared to act as a facilitator to help set up future schemes. However, it was not HSE's role to decide what these schemes should consist of or to run them. He also highlighted the section of text in the draft leaflet attached to the paper, which states that while a passport does not imply that the passport holder is competent, it does provide information on the training that they have had. Members were asked for their thoughts on this issue.

Mr Atkinson informed members that a safety passport scheme had been started off on the River Tyne although it had not been possible to continue the necessary funding for this. Instead they transferred it to a skills database in which health and safety was an intrinsic element. They have also developed a computerised induction. The initiative which is ran by the Tyne Maritime Group also involves bringing together their procedures, for example by standardising the colour coding of burning pipes. Currently the initiative has hit a bit of a hurdle, which they are trying to get over.

Mr Granger advised members that 250 000 people have been issued with a passport in the construction industry, this was therefore not a coming issue as it is here already. The construction industry started off with the CITB health and safety passport scheme, which was also changed to a skills database. The skills etc. are downloaded onto a card and people need to swipe the card in order to get onto a building site. Mr Lomas felt that what the shipbuilding/repair industry really needs is a skills database card due to the problem of people leaving the industry when made redundant and being replaced by new people without the same skills.

Mr Sykes said there were two ways to progress this issue, the industry can either use an existing scheme and graft onto it or develop a new system for itself. Mr Granger responded that the CITB had managed to secure £7,000,000 of government funding and that he would look into this. Mr Atkinson also confirmed that money was available to fund such schemes. Mr Sykes commented that the difficulty was deciding how to progress with this; it

needed somebody to make it happen although the HSE will provide assistance.

Mr Granger said the SSA will undertake to do a bit of thinking on this and will prepare a discussion document. Mr Lomas asked that the focus be on a skills database and not on a health and safety scheme alone, on which the other members agreed. Mr Granger said he would speak further about this with Mr Atkinson who agreed to put Mr Granger in touch with Mr Needham who is involved with setting up the database on the Tyne.

Action: Mr Granger and Mr Atkinson.

## **10. PLATE CLAMPS**

Mr Watson presented paper 44C informing members of an accident involving a plate clamp operated by friction. A metal plate was dropped from the clamp because it weighed less than the clamps minimum safe working load. Plate clamps have to be stamped with their maximum safe working load but not their minimum safe working load. As a result the significance of this issue for clamps, which operate by friction can be overlooked. Members were asked to investigate the clamps used in their yards to see if this was an issue for them and if so could they report back at the next meeting with the manufacturer's details, the minimum safe working load and whether this is marked on the clamp or detailed in the clamp's operating instructions.

Action: Members

## **11. INSTITUTE OF OCCUPATIONAL MEDICINE – RISKOFDERM**

Mr Watson referred to the letter forwarded to a number of members regarding the research project ran by the Institute of Occupational Medicine (IOM) looking into dermal exposure to hazardous substances. The project of which HSE is one of the managing partners seeks to produce an exposure model so that exposures for workplace scenarios can be more accurately predicted and a management tool-kit produced to provide advice and assistance in controlling the risks to health. The IOM were looking to visit shipyards applying hazardous substances in order to measure exposure levels. Some yards have already offered to help with the research. Graeme Hughson from the IOM has offered to attend a future SSHSCC meeting to brief members on progress being made. Mr Allison queried the reference in the IOM letter to coatings containing copper. Mr Sykes thought the main implications regarding copper were in relation to the environment.

## **12. EUROPEAN DIRECTIVE UPDATE**

Mr. Sykes updated members on the further development of the Temporary Working at Heights, CAD/ATEX, and the Physical Agents EC Directives.

The Temporary Work at Height Directive was formally adopted on 14 June 2001 and amends for the second time the Use of Work Equipment Directive.

A full copy of the Directive can be found on HSE's website at <http://www.hse.gov.uk/spd/noframes/spdwem.htm#ecdir> The Directive sets minimum requirements for the selection and use of access equipment for work at a height, with specific requirements relating to scaffolds, ladders and rope access equipment. It adopts a hierarchical approach to the selection of equipment, e.g. scaffolding in preference to ladders, etc. The Directive does not address mobile elevating platforms or equivalent means of access.

The UK has until 19 July 2004 to make implementing regulations and until 19 July 2006 before the Regulations must come into force in full. HSE intends to implement the Directive by July 2003 if possible, in order to give industry the maximum time possible to adjust to the new Regulations. Implementation will be by a set of stand-alone regulations applying to work at height in all sectors of industry. Consultation on the proposals is likely to take place November 2002 to February 2003.

Mr. Paton queried what the impact will be of the new regulations on the Shipbuilding Regulations. Mr. Sykes explained that they will replace the regulations relating to staging resulting in a common standard for all scaffolding/staging. Members discussed the difficulties caused by the present situation where there are different standards for scaffolding/staging. Mr. Sykes stated that HSE's views on this issue were contained in the HSE Information Document *Staging around ships and boats in build and repair yards* (available on the HSE web site at: [http://www.hse.gov.uk/fod/730\\_12.pdf](http://www.hse.gov.uk/fod/730_12.pdf))

The first stages in implementation of the Chemical Agents/ATEX Directive are now well advanced. These include: i) revised proposals for amendments to the Control of Asbestos at Work Regulations and a new supporting Approved Code of Practice. This document contains revised proposals for amendments to the Control of Asbestos at Work Regulations 1987, which arose as a result of comments received during consultation which took place during 2000 (Consultative Document CD159). Consultation on the proposals ended 19 February 2002. ii) new Control of Substances Hazardous to Health Regulations and Control of Lead at Work Regulations which will implement the health aspects of the Chemical Agents Directive (CAD). Consultation on the proposals including the revised COSHH ACoPs ended 21 January 2002.

Mr. Watson updated members on the latest position of the Dangerous Substances and Explosive Atmospheres Regulations (DSEAR), which will implement the safety aspects of the Chemical Agents/ATEX Directive. The Regulations will require employers and the self-employed to: i) carry out a risk assessment of any work activities involving dangerous substances; ii) provide technical and organisational measures to eliminate or reduce to as far as is reasonably practicable the identified risks; iii) provide equipment and procedures to deal with accident and emergencies; and iv) provide information and training to employees. While the Regulations will not contain anything fundamentally new Mr. Lomas felt they could end up spending a lot of their time verifying their procedures making sure that they do comply with the Regulations. Consultation on the proposals ended on 20 May 2002 (CD 180 on the HSE web site at: <http://www.hse.gov.uk/condocs/closed/cd180.htm>) It is expected that the new

Regulations will be in force in August 2002 although it is possible that the ACoP and guidance on the safety requirements may be delayed. Unless the Regulations are in force by August Britain may be in danger of infraction proceedings. The main focus of attention is therefore on the regulations hence the delay in the associated guidance.

### **13. SSA Health and Safety Guidance**

Mr. Watson continued the review of existing SSA health and safety guidance beginning with the risk assessment guidance. Members agreed that this guidance had now served its purpose and should therefore be deleted. It was also agreed that guidance notes 2 and 4 covering storage and use of fuel gases on board ships and hot work would be redrafted although this would wait until the Dangerous Substances Regulations were in place. Mr. Allison felt the hot work guidance did not contain much guidance on adjacent spaces including the use of sentries etc. it was agreed that this issue could be incorporated into the redrafted guidance. In relation to guidance note 3 advising on work in confined spaces members agreed that this should be updated and redrafted to take into account lessons to be learnt from the Glomar Artic incident. Guidance note 5 had been reviewed at a previous meeting. Guidance note 6 regarding the use of pad eyes was discussed and was felt to require updating. Mr. Allison also believed that it should be amended to contain information on the chemical composition of steel, the effect on steel of heat treatment and the difficulties caused by people using incorrect welding procedures, this was agreed.

Guidance note 7 regarding the control of contractors was also discussed. Mr. Watson felt while this was relatively comprehensive and did not require much updating there was perhaps scope to improve on the appendices. Mr. Allison also felt that some additional rewording of the main text was also required. This should highlight the issue of contractors seeking to discharge their duties and work up to shipyards asking ship owners for more time to complete the work. Mr. Allison agreed to help with redrafting the guidance note.

Action: Mr. Allison

It was agreed that the guidance note advising on the safe use of anti-fouling coatings required only cosmetic updating including the correction of a number of grammatical errors.

The order in which the guidance notes should be redrafted and updated was discussed. It was agreed that the first guidance note to be redrafted should be the housekeeping guidance given the high incidence of slip and trip accidents. No new regulations were also expected in the near future concerning this issue. Mr. Paton and Mr. Arkle volunteered to form a working party with Mr. Watson to redraft the guidance.

Mr. Granger was asked what the procedure would be for deleting guidance notes that were not felt to be worth keeping. Mr. Granger said that this would be achieved by issuing a new appendix sheet and asking people to remove the deleted guidance notes from their set of guidance. Mr. Granger also

advised members that the text of all the guidance notes had now been captured electronically and so can be readily manipulated. The guidance notes will also shortly be appearing on the SSA's web site on a password protected area.

#### **14. REVITALISING HEALTH AND SAFETY**

This issue was not discussed due to a lack of time and will be carried forward to the next meeting.

#### **15. HSC/HSE PRIORITY PROGRAMMES**

Due to a shortage of time this topic was not discussed members were asked instead to read paper 44/E, which was self-explanatory.

#### **16. ENFORCEMENT POLICY**

This issue was not fully discussed, members were again asked to read the accompanying paper (44/E). Mr. Lomas made a request that HSE Inspectors consider the management chain as indicated by the enforcement policy. He believed that a letter from an HSE Inspector even if just a "minded to" letter, which identifies the failings of individuals, travels around a company quicker than a corporate prosecution and helps to focus peoples' minds better. Mr. Lomas also felt there should be more focus on production directors and not just on directors responsible for safety. Mr. Sykes replied that guidance on the duties of directors had been raised at previous meetings and that this gives a steer as to the way HSE is moving on this issue.

#### **17. LANYARD SAFETY**

This issue was not fully discussed members were instead directed to paper 44/G. Mr. Watson emphasised the importance of the advice contained in the paper especially that in paragraph 3 which details the findings of research into the causes and effects of damage to energy-absorbing lanyards made from webbing or rope. The research identified that a one millimetre deep nick or cut in the edge of a webbing lanyard can result in a 5 to 39% loss of strength. The research confirms the vital importance of pre-use checks and regular documented inspections of fall arrest equipment.

#### **18. HEALTH AND SAFETY NEWS UPDATE**

Mr. Watson distributed a health and safety news update (enclosed for members not at the meeting).

#### **19. ACCIDENTS INVESTIGATED IN SHIP AND BOAT YARDS**

Mr. Watson distributed paper 44/H (copy attached for members not at the meeting) and apologised for not including it with the other papers sent out with the agenda. Members were asked to read the paper in their own time. Mr.

Watson commented on the small number of accidents that had been investigated and hoped that this was an encouraging sign.

## **20. ANY OTHER BUSINESS**

Members were advised that the enclosed letter from the Royal Free and University College Medical School requesting assistance with a research project would be circulated with the minutes. The project involves assessing the combined impact of occupational exposure to solvents and noise on hearing. Contact details are to the rear of the letter for any members interested in taking part in the study or who would like further information on what is proposed.

## **21. DATES AND VENUES**

The remaining meetings in 2002 are:

18 September 2002 – DML, Plymouth

4 December 2002 – Gosforth Cricket Club, Newcastle-upon-Tyne