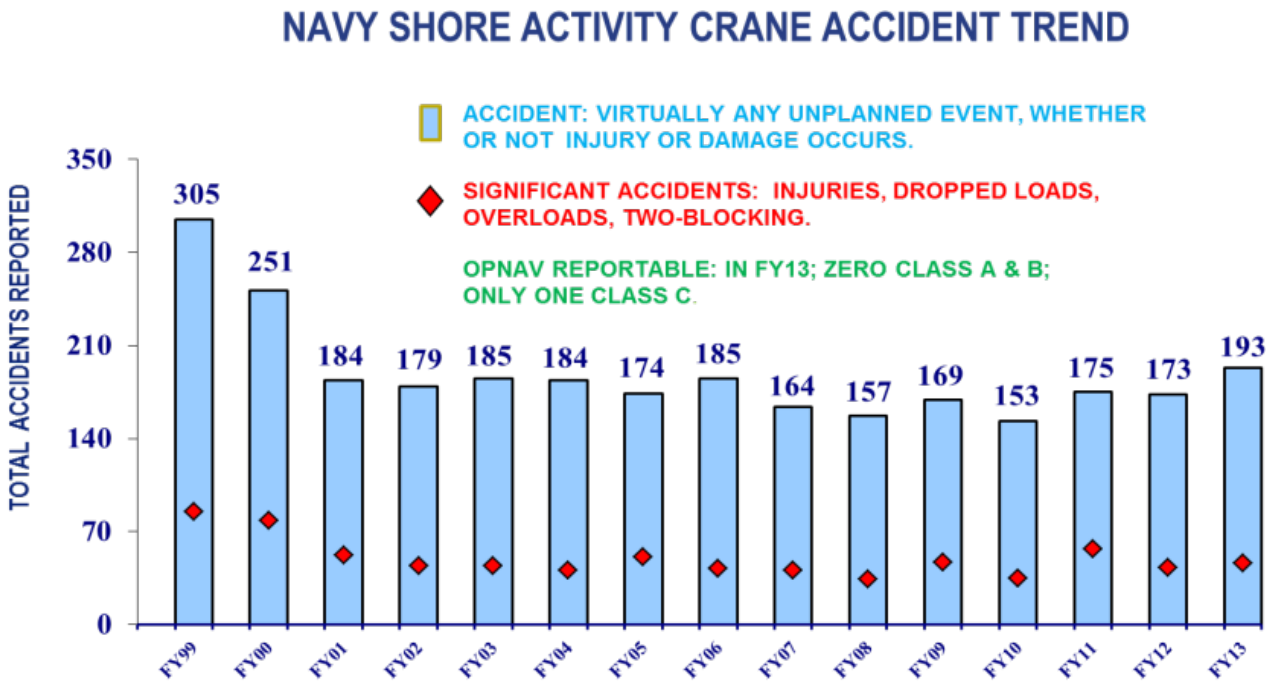
WEIGHT HANDLING EQUIPMENT ACCIDENTS

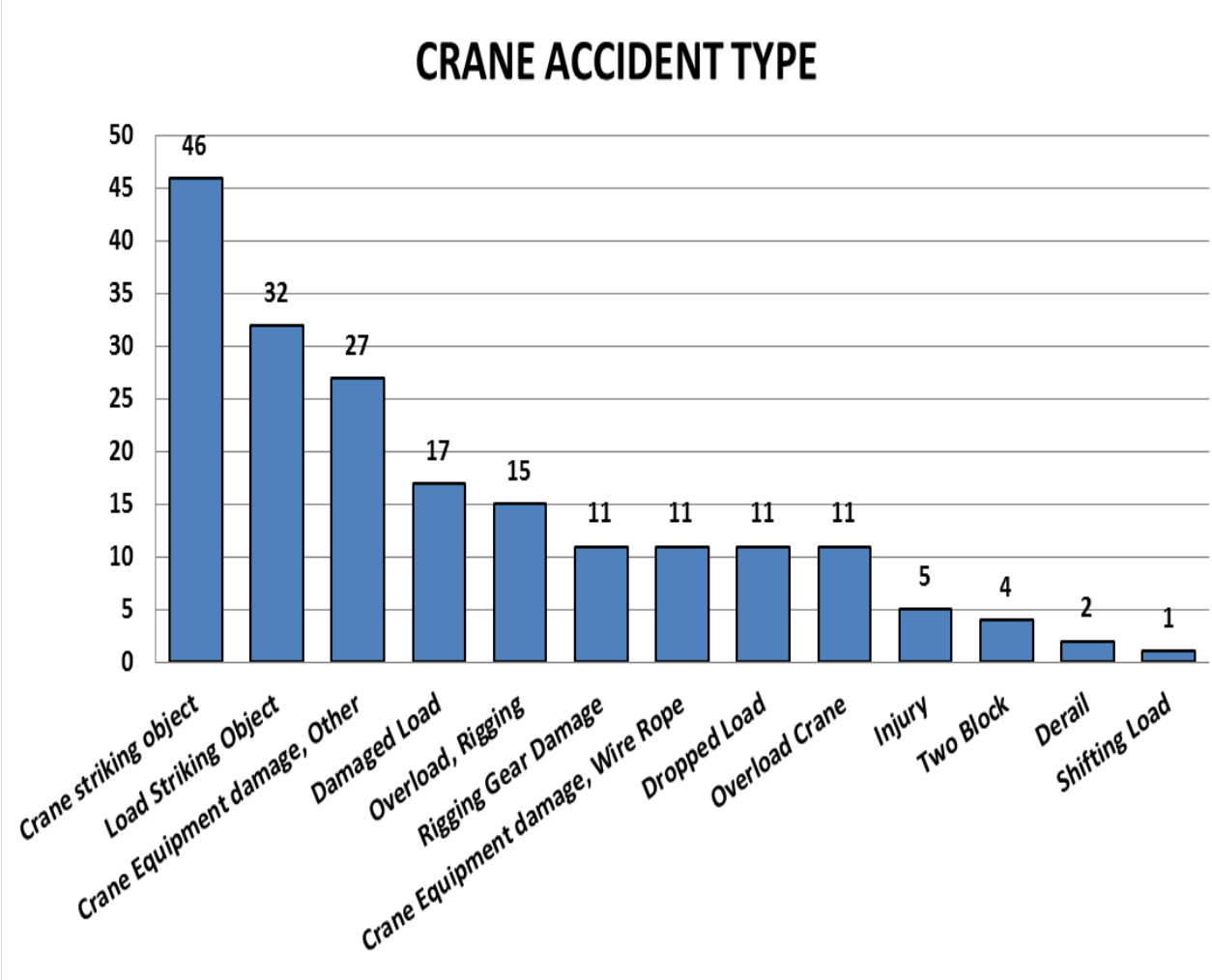
To maintain our intense focus on SAFETY, we have very rigorous crane and rigging gear accident definitions that include essentially any unplanned event in a weight handling evolution whether or not injury or damage occurs. The basic strategy is that ALL accidents (regardless of severity) must be reported to ensure we benefit from the lessons learned to prevent more serious accidents from occurring. We have encouraged all Navy shore activities to make the principles of OPNAVINST 3500.39C, Operational Risk Management (ORM), standard practice for every weight handling operation. This includes operating a crane without a load. In FY13, 44 percent of all crane accidents occurred with no load on the hook. Consistent application of ORM principles during every crane operation will significantly reduce accident severity. Human error continues to be the primary cause of most accidents. We continue to encourage Navy shore activities to drive toward our goal of continuous improvement of safety in weight handling operations. We also strongly encourage activities to investigate and report near misses and other unplanned events that do not fall under our accident definition. Learning from such events can prevent accidents from occurring and significantly improve operational efficiency. The submission of Navy weight handling near miss reports increased 55 percent (177 vs 114) over FY12. As recent as FY10, the number of near misses reported was 29. This illustrates how activities are embracing the concept of identifying, correcting, documenting, and sharing lessons learned from tangible anomalies that have the potential to lead to an accident. Activity deckplate operations oversight has contributed to this very positive trend.

CRANE ACCIDENTS

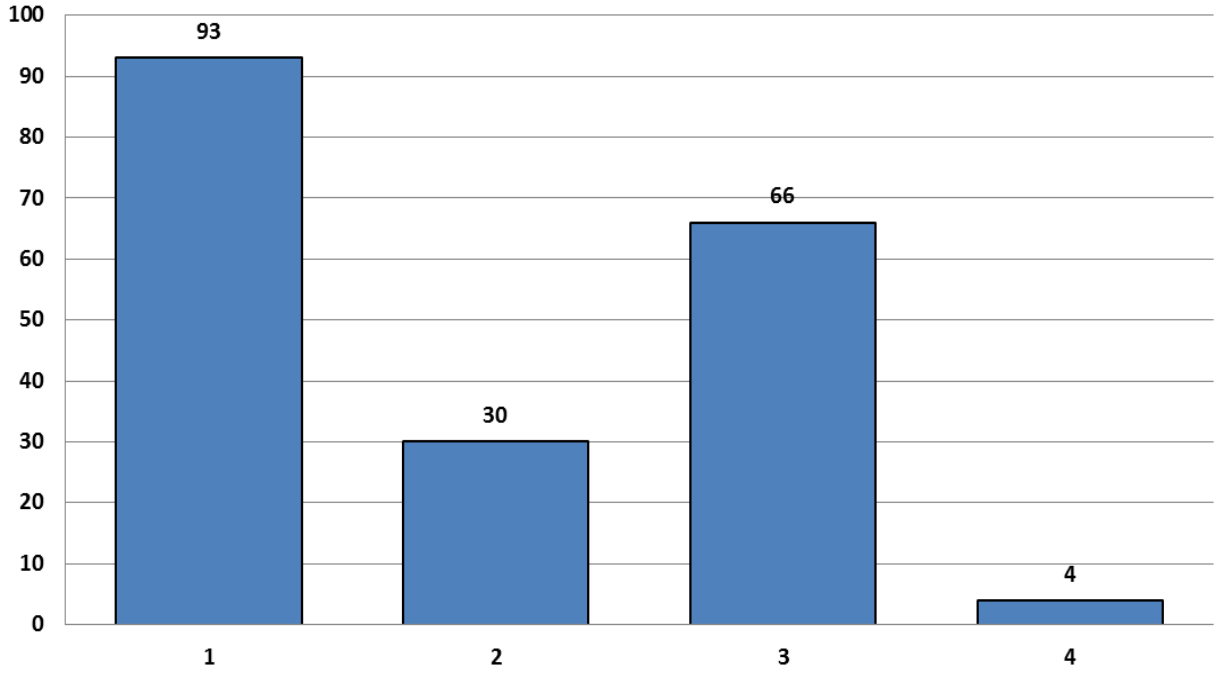
The FY13 crane accident total is 193 as of the date of this publication (46 significant) compared to 173 and 43, respectively, for FY12.



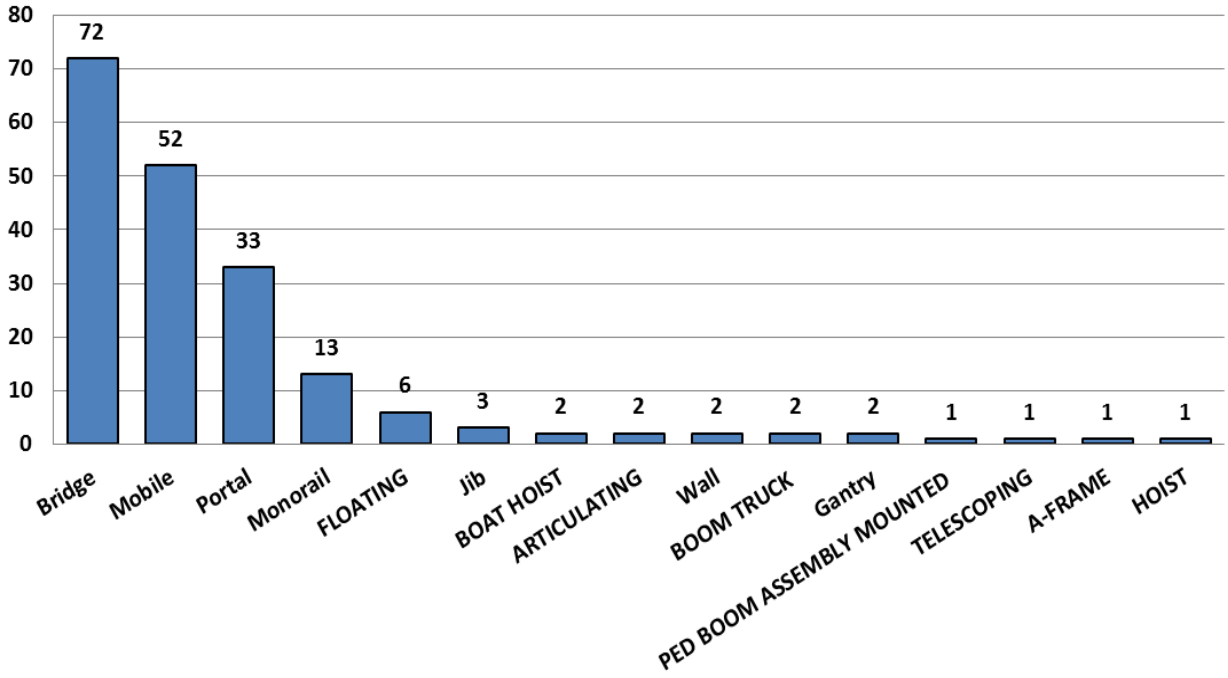
Accidents that are considered significant (dropped loads, two-block, overloads, and accidents involving injuries); i.e., those accidents that have the potential to be more serious, increased approximately 7 percent over the FY12 total, primarily due to an 88 percent increase in rigging gear overloads. Of particular note, only one reported Navy crane accident met the OPNAV accident classification "C" threshold (lost time injury or resulting material damage $50,000 to $500,000) during FY13. Considering the several million lifts that are made each year, this is a major accomplishment! Accidents involving collisions represented 40 percent of all crane accidents. While FY13 saw a 13 percent decrease in crane collisions, load collisions increased 52 percent as compared to FY12. On a very positive note, there was a 60 percent decrease in crane two block accidents as compared to the FY12 totals.



ACCIDENTS BY CRANE CATEGORY



ACCIDENTS BY CRANE TYPE



RIGGING GEAR ACCIDENTS

Rigging gear accidents are those that occur when gear covered by NAVFAC P-307 section 14 is used by itself in weight handling operations; i.e., without category 1 through 4 cranes. In FY13, 65 rigging gear accidents were reported as compared to 50 in FY12. The combined significant accident categories of personal injuries, dropped loads, overloads, and two-blocking accidents accounted for 24 of the 65 accidents (37 percent vs 34 percent in FY12). Eight of the significant rigging gear accidents resulted in minor injury to a person within the weight handling envelope.