Confined space fatality in shipyard

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A rope access worker lost his life in a fatal incident at a fabrication site.

What happened?

The rope access worker was tasked to descend into a 90cm diameter and 30m depth Riser Guide Tube (RGT) via the rope access method, to retrieve a piece of foam from the RGT. After descending for about 5 minutes, the worker lost contact with his co-workers on top of the RGT. He was rescued and immediately conveyed to hospital by the yard's ambulance, but was pronounced dead by the attending doctor.

What went wrong?

- A Permit to Work was authorized and issued without Job Safety Analysis having taken place for high-risk confined space entry activity
- Suitable rescue equipment for confined space entry was not available at site location. No written procedure/method statement was available during Job Safety Analysis (or briefed to the work crew before implementation)
- No pre-entry gas test immediately before entry into confined space (or recognition that the activity would itself release confined gas).

The corrective actions and recommendations were:

- Elimination of need to enter confined space. Method changed to eliminate need to enter confined space
- Risk assessment – Construction supervision/expertise should attend all risk assessments relating to their area of responsibility
- Training – shipyard should provide training relating to the correct use of and wearing of personal gas detectors
- Job Safety Analysis (JSA) meetings on the project must be approved by all parties prior to the associated work permit being granted
- Emergency extraction – shipyard should ensure that mechanical means of man extraction are available at all times during rope access.

Members may wish to review Guidance on safety in shipyards.

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