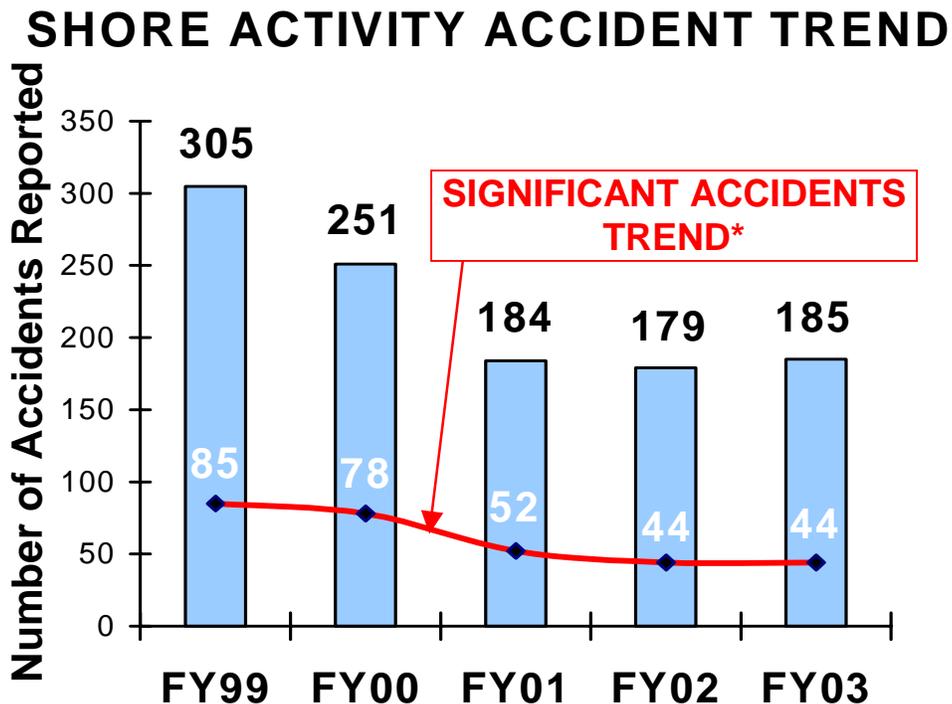


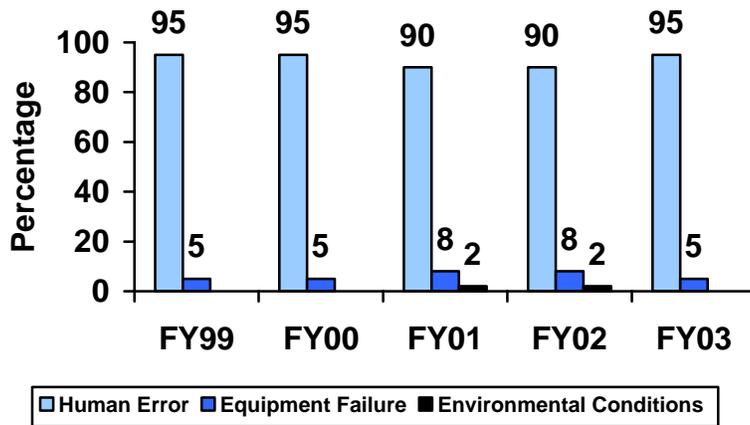
WEIGHT HANDLING EQUIPMENT ACCIDENTS

Despite the increased tempo of weight handling operations, Navy shore activities maintained the excellent safety record achieved in the past few years. The combined significant accident categories of personal injuries, dropped loads, overloads, and two-blockings accidents continue to be a small percentage of total accidents. Only one of the accidents met the threshold for reporting to the Naval Safety Center as required by OPNAVINST 5100.23. Of the nine injuries, only three resulted in lost work time. In FY03, we established a new category of accident, the rigging gear accident, to focus additional safety on rigging operations that are performed without cranes, such as those performed below deck on ships. Our emphasis on having activities report ALL accidents (no matter how minor), our regular promulgation of accident lessons learned, our training initiatives, and our periodic audits of Navy shore activities support this continuing positive trend. To maintain our intense focus on SAFETY, we have a very rigorous crane accident definition that includes essentially any unplanned event in a weight handling evolution whether or not injury or damage occurs, using the basic strategy that ALL accidents (regardless of severity) must be reported to ensure we benefit from the lessons learned to prevent more serious accidents from occurring. Ninety-five percent of crane accidents are due to human error. We have encouraged all Navy shore activities to make the principles of OPNAVINST 3500.39A, Operational Risk Management (ORM), standard practice for each and every weight handling operation. Increased safety awareness by all personnel involved in weight handling operations and consistent application of ORM principles will help prevent accidents. We continue to encourage the Navy shore establishment to drive toward our goal of ZERO crane and rigging gear accidents.

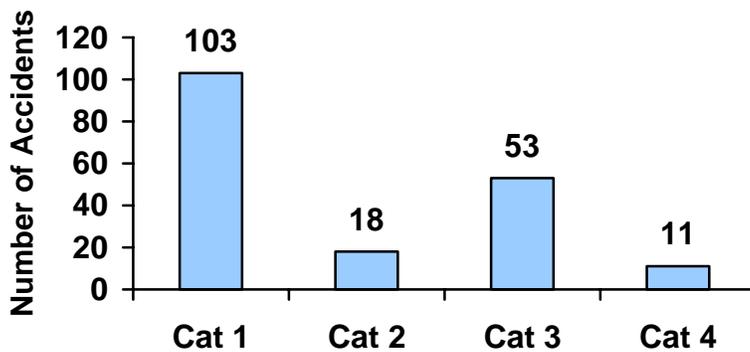


* Combines: injuries, dropped loads, overloads, and two-block accidents.

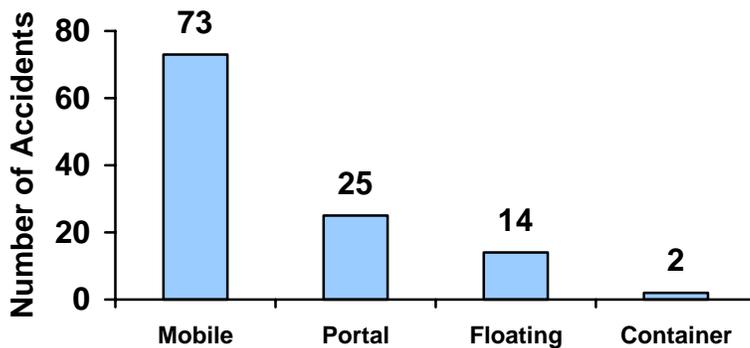
WHE ACCIDENT CAUSES



FY03 ACCIDENTS BY CRANE CATEGORY



FY03 CAT 1 & 4 BREAKDOWN BY TYPE OF CRANE



Although they account for only 8 percent of the WHE inventory, mobile cranes are involved in 39 percent of all WHE accidents.

WHE ACCIDENT TYPES*

	FY99	FY00	FY01	FY02	FY03
Personal Injuries	17	16	12	7	9
Dropped Loads	26	10	15	18	13
Two-Blocks	19	21	12	12	12
Overloads	23	32	14	13	15
Damaged Cranes	88	86	60	53	51
Crane Collisions	37	37	37	38	31
Damaged Rigging Gear	27	8	16	12	10
Damaged Loads	30	14	13	11	21
Derailments	1	2	1	1	4
Load Collisions	24	17	19	16	25
Equipment Failures	13	8	15	14	9

* Some accidents may include more than one type.

HUMAN ERROR

	FY99	FY00	FY01	FY02	FY03
Improper Operation	163	129	93	77	82
Improper Rigging	51	24	29	22	37
Procedural Failure	53	54	26	44	NA
Inadequate Procedure*	NA	NA	NA	NA	8
Failure to Follow Procedure*	NA	NA	NA	NA	24
Inadequate Communication	23	24	14	15	18
Inadequate Visibility	3	2	2	0	1
Inadequate Maintenance	NA	4	2	3	1
Inadequate Inspection	NA	1	0	0	0
Switch Alignment	NA	NA	NA	NA	4

* New categories to reflect inadequate procedures and failing to follow procedures. Previously combined in Procedural Failure.

PERSON RESPONSIBLE*

	FY99	FY00	FY01	FY02	FY03
Operator	109	125	98	81	71
Rigger	86	62	58	28	46
Contractor	6	6	2	1	4
Crane Team	10	37	33	14	12
Engineering or Technical	2	2	6	2	5
Inspection	3	1	5	2	0
Maintenance	14	4	8	11	7
Management	62	35	30	19	24
Manufacturer	1	3	3	0	0
Shops	7	2	3	7	8

* Some accidents are charged to more than one person.