

4
August
2022

WSH ALERT

FATAL ACCIDENT

Trainer fell overboard and was struck by propeller

On 20 July 2022, a diving trainer was at a jetty operating a dinghy equipped with an outboard motor (OBM) when he fell overboard. The unmanned dinghy continued moving, and hit a docked vessel and jetty structure, before turning back towards the trainer. The trainer was struck by the OBM's propeller and died at the scene.

Preliminary investigations found that the trainer was alone on the dinghy at the time of the accident.



Dinghy involved in the accident.

Recommendations

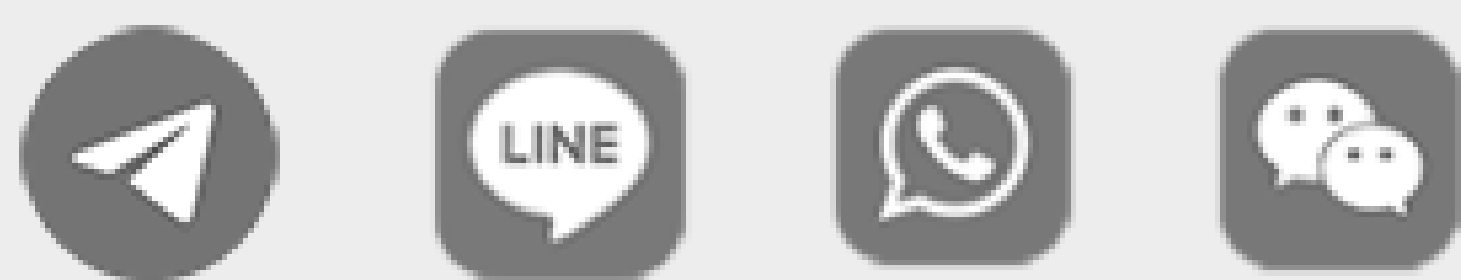
This case shows the danger of an unmanned dinghy or boat. OBMs are machines with an exposed propeller and contact with moving propellers can cause severe injury or death. To prevent similar accidents, consider the following measures:

- Kill-switch lanyard:** Require the use of an engine kill-switch lanyard in the OBM safe work procedure. Instruct OBM operators to attach the kill-switch lanyard to their wrist or life jacket before starting the engine. If the operator moves away from the OBM or falls overboard, the lanyard will automatically stop the engine.
- Safer throttle by design:** As an alternative to a kill-switch lanyard, consider deploying OBMs with engine throttles that come with a built-in cut-off switch (i.e. the engine will turn off once the operator's hand leaves the throttle).
- Worker training:** Allow only competent operators who have completed safety and health training to handle an OBM.
- Life jacket:** Provide each worker exposed to the risk of falling into water with a life jacket. Check that life jackets are in good condition before use and ensure workers put on the life jackets before working near or in water bodies.
- Emergency response:** To familiarise workers on what to do in an emergency, conduct regular man-overboard drills for workers working near or in water bodies. Consider deploying OBM operators in two-man teams and deploy a back-up team on shore to provide emergency response support.

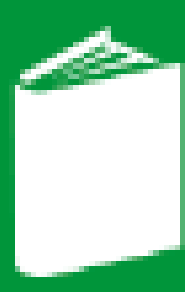
For more information, please refer to WSH Council's [Code of Practice on WSH Risk Management](#).

* Information on the accident is based on preliminary investigations by the Ministry of Manpower as at 1 August 2022. This may be subject to change as investigations are still on-going. Please also note that the recommendations provided here are not exhaustive and they are meant to enhance workplace safety and health so that a recurrence may be prevented. The information and recommendations provided are not to be construed as implying liability on any party nor should it be taken to encapsulate all the responsibilities and obligations under the law.

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