



IRATA SAFETY BULLETIN SB24 OUT OF CONTROL ABSEILS

Issue Date	November 2012
Issuer	IRATA Health & Safety Committee
Status	A Report following an IRATA member company report B Incident notified by a UK HSE inspector (Non IRATA company)

A1 UK Incident (IRATA Member Company)

On the afternoon of his first day at work an IRATA level 1 whose first language is not English, went out of control from a mid rope point for approx 10m, resulting in a fractured pelvis.

He was using a Stop descender and Shunt back-up device [with towing cord removed], but his level 1 training out of UK a month previously listed training with Petzl I'D and Singing Rock Locker.

He was checked prior to descent by a level 3 at the top, and abseiled parallel to a level 2 technician who spoke the same language and who was showing him how to do the drilling etc.

A2 Incident analysis

- 2.1 Use of different equipment from that trained.
- 2.2 Was use of Shunt without a towing cord relevant - potentially more likely to grab the shunt body which is a known foreseeable misuse for any use of the shunt, as noted in manufacturer's instructions & Shunt statement?
- 2.3 IP's first language is not English, so possibly some misunderstanding because of language?

A3 Control measures

- 3.1 Risk assessment and method statement to address language issues. Provide workers with comprehensible and relevant information about risks, procedures they need to follow and to ensure they understand and can work safely.
- 3.2 Adequate training /familiarisation /competence check for equipment issued, particularly if different from that previously trained.
- 3.3 Close supervision for newly qualified technicians and reminder of pre-descent function check [mini abseil] without holding back-up device.
- 3.4 Use of descender for novices with anti-panic function i.e. squeezing handle causes it to lock.
- 3.5 Consider attaching two technicians together where they are abseiling close together.
- 3.6 Use of friction karabiner below descender to give greater control, minimising initial problem.
- 3.7 Use of 'blocking knot' tied in working line, or 'bottom belay' by technician on ground.

B1 UK Incident (NON IRATA COMPANY)

An IRATA level 1 window cleaner had stopped at a height of approx 4m from the bottom of an 80m drop; the descent was jerky as it was wet. On continuing he went out of control and landed awkwardly across a barrier, resulting in spinal injury.

He was using a Stop descender and Shunt back-up device.

B2 Incident analysis

The elongation on 80m of the safety line would be in excess of 4m, so the braking action on of any type of back-up device would have been ineffective once out of control.

B3 Control measures

- 3.1 Risk assessment and method statement to recognise rope elongation and clearance distance problems on the lower section of any, but particularly long abseils.
- 3.2 Minimise rope elongation/ stretch, e.g. If possible re-anchor working and safety lines, pre-tension safety line, use double descender, or a second descender as an alternative to a back-up device.
- 3.3 Use of a descender with anti-panic function i.e. squeezing handle causes it to lock.
- 3.4 Use of friction karabiner below descender to give greater control on wet rope.