

Doc. No.: HS-234ENG	<h1 style="margin: 0;">IRATA</h1> <h2 style="margin: 0;">Safety Bulletin No. 47</h2>	
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*A safety bulletin prepared by © IRATA International (2017)*

## SAFETY BULLETIN NO. 47: WORKING IN A BUNKER – DANGEROUS OCCURENCE

*A safety bulletin aimed at raising awareness of hazards in the rope access industry. The text may be of use as part of a toolbox talk.*

### **DISCLAIMER:**

*This safety bulletin - including, where given, any conclusions - is not as a result of any investigation undertaken by IRATA. It is based on information provided by a member company. IRATA does not attribute any blame; nor provide opinion on any root causes. Neither is any opinion expressed or implied on liability or culpability. The following summary is provided to assist others in applying any 'lessons learnt'. Rope access is defined in the IRATA ICOP, Part 1, 1.3, Definitions. In essence, it is a two-rope system (working line and safety line). For the purposes of this summary, any reference to 'on-rope' or 'off-rope' should be construed accordingly.*

## **1 INTRODUCTION**

- 1.1 This safety bulletin summarises a dangerous occurrence that took place whilst rope access technicians were cleaning the internal walls of a limestone bunker.

## **2 BACKGROUND INFORMATION**

- 2.1 Date of incident: February 2017.
- 2.2 Injured persons: None.

## **3 WHAT WENT WRONG**

- 3.1 Rope access technicians were cleaning the internal walls of a bunker containing limestone, using high impact percussive hammers ('kango').
- 3.2 The work commenced on the south face. Whilst this was being undertaken material from the north side slid downwards.
- 3.3 Due to the viscosity of the material, two Level 2 rope access technicians were trapped up to and including their waist.
- 3.4 The L3 immediately raised the site alarm and the on-site emergency services were deployed to assist with the retrieval/rescue of the technicians.
- 3.5 The technicians were retrieved/rescued without injury and taken to a local hospital for a check-up; and discharged without injury. They all returned to work the following day.

## **4 REMEDIAL ACTIONS**

- 4.1 To prevent a recurrence the method statement was changed:
- 4.2 On the north elevation the rope access technicians, using high impact percussive hammers, cleared away the compacted limestone to a depth no greater than 1 metre from the top of the hopper.

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- 4.3 Moving themselves to the east elevation the same process was followed, only removing a maximum of 1 metre of debris at a time. This was repeated sequentially, moving clockwise.
- 4.4 Once enough material had been removed and built up in the bottom of the hopper the technicians removed themselves from the hopper and draw all their ropes up onto the access platform surrounding the hopper.
- 4.5 The Level 3 then removed the lock-out isolation, as directed by the client, to allow the transfer of the materials from the bottom of the hopper.
- 4.6 These steps were repeated so that all technicians were out of the hopper until material had been removed.

## 5 DISCUSSION

- 5.1 Steps should be taken, where necessary to prevent danger to any person, to ensure that any material does not collapse or become unstable, i.e. be in a temporary state of weakness or instability.
- 5.2 Consideration should be given to the placing of any excess anchor line for the descent in a bag and suspending it beneath the rope access technician. This can prevent anchor lines from becoming entangled or damaged by any falling debris, e.g. when removing rock during slope stabilisation (ICOP, Clause 2.11.3).
- 5.3 Care is necessary to remove loose material before descending and it is important to be aware of the possibility that any movement of the anchor line could dislodge material above, which could fall onto the rope access technician (ICOP, Clause 2.11.3).

## 6 FURTHER INFORMATION

- 6.1 Further information can be found in:
  - (a) IRATA International code of practice for industrial rope access (Third edition)<sup>1</sup>:
    - o Part 2, 2.11.3, Use of anchor lines
- 6.2 For a list of current (and past) 'safety communications' by IRATA, see [www.irata.org.uk](http://www.irata.org.uk)

## 7 RECORD FORM

- 7.1 An example *Safety Bulletin: Record Form* is given below. Members may have their own procedure(s) for recording briefings to technicians and others.

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<sup>1</sup> <https://irata.org/downloads/2055>

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IRATA SAFETY BULLETIN – RECORD FORM			
<b>Site:</b>			
<b>Date:</b>			
<b>Topic(s) for discussion:</b>		Safety Bulletin No. 47: Working in a silo – dangerous occurrence	
<b>Reason for talk:</b>			
<b>Start time:</b>		<b>Finish time:</b>	
<b>Attended by</b> <i>Please sign to verify understanding of briefing</i>			
<b>Print name:</b>		<b>Signature:</b>	
<i>Continue overleaf (where necessary)</i>			
<b>Matters raised by employees:</b>		<b>Action taken as a result:</b>	
<i>Continue overleaf (where necessary)</i>			
<b>Briefing leader</b> <i>I confirm I have delivered this briefing and have questioned those attending on the topic discussed.</i>			
<b>Print name:</b>		<b>Signature:</b>	
			<b>Date:</b>
<b>Comments:</b>			