IRATA SAFETY BULLETIN
SB34 Fall From Height During IRATA Level 1 Revalidation Training

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Issue No.	SB34 Fall From Height During IRATA Level 1 Revalidation Training
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1. The Incident

Incident occurred on 16 July 2014 at 10.30am at an indoor training area operated by a Trainer Member Company (TMC).

The affected person was a Level 1 candidate (IP1) on the first day of a two-day IRATA Level 1 revalidation course. IP1 had over 6 years experience at IRATA Level 1 with 400 hours in his logbook.

There were three TMC staff on site at the time of incident:
L3T1 = IRATA Level 3T trainer on duty;
L3T2 = TMC director, teaching theory in classroom;
OM= TMC Office Manager, in office.

There were seven trainees on site at the time of incident:

Four Level 1 candidates including IP1 in training area with L3T1;

One L3 candidate and two L2 candidates in classroom with L3T2;

The other three L1s had been with the TMC since Monday. Two were experienced technicians revalidating and one was new to the industry. All were progressing well with training allowing L3T1 to initially focus his attention on IP1.

After assembling equipment, L3T1 took IP1 through some initial manoeuvres: ascent and descent with ascenders; then up with ascenders and change to descender and descend; this was carried out twice.

With IP1s prior experience and performance on these initial exercises L3T1 was happy to move onto more complex manoeuvres, starting with a rope-to-rope transfer. IP1 completed the first half of the exercise successfully, changing from ascent to descent, connecting to the new ropes with chest ascender and knot, and lowering across. L3T1 advised IP1 of the remaining steps to complete the exercise and turned his attention to the other L1 candidates. A short time later IP1 fell the short distance (approximately 2m) to the floor clutching ropes, burning his right hand and landing hard on his left leg, hurting his ankle. IP1s handled ascender and foot loop were still on the rope, but he had no connections to the ropes. IP1 said he thought he had put his descender on the rope before removing his chest ascender, but it was evident he had not. Likewise his back-up device was not connected, he had untied the knot and had not connected to his handled ascender.

NB: the initial report in the TMC accident book suggests the back-up did not engage due to insufficient height. Further discussion with L3T1 and IP1 suggests the back-up had in fact been disconnected.

2. Incident analysis

Although IP1 considered the accident his own fault, it could have been prevented through closer supervision. Supervision was at the TMCs normal level (4:1), and is lower than IRATA's maximum candidate/trainer ratio of 6:1. IP1s experience and initial performance were not indicative of him requiring special attention or a higher level of supervision.

Whilst the potential for such accidents is always present when training it is not possible to watch everyone 100% of the time, but a quick check to confirm at least one good connection had been made would have been sufficient to prevent the fall.

The incident required IP1 to make **all** of a series of mistakes:

- Not re-attaching his descender,
- Not re-connecting his back-up,
- Not disconnecting from the knot,
- Not making a connection to his handled ascender,
- Not checking all of the previous before disconnecting his chest ascender.

The avoidance of any one of these mistakes would have prevented the accident.

Equipment selection was not considered to be a factor here.

This is the first time any of the TMCs trainers have witnessed such an incident in many years experience and it is considered to be very unusual. IRATA's accident statistics confirm that such occurrences are very rare.

The TMC report that the only unusual factor present was that IP1 was attempting to revalidate in 3 days and perhaps therefore felt pressure to 'catch-up' with the other L1 candidates who had been present since Monday.

3. Control measures implemented

IP1 was advised by the TMC to have at least a day's rest. As this would leave him unable to complete the course the same week it was agreed to reschedule on the 4 August, for a full four days (which became mandatory in the intervening period with the release of the Training Assessment and Certification Scheme on 01 August) of training. The TMC noted that in light of this incident it would seem prudent to insist all candidates attend the 5-day course; coincidentally IRATA introduced this as a requirement in the same period.

The TMC held a toolbox talk with all trainers to discuss how the accident could have been prevented. The incident affirmed the worth of keeping an attachment to the handled ascender, which although not mandatory the TMC teach as good practice.

4. Postscript

IP1 re-attended training without further incident, and was successfully assessed and re-certified at IRATA L1 for 3 years.

5. Further Reading

Further reading for candidates attending training courses can be found in IRATAs Training, Assessment and Certification Scheme (TACS) in section 4. - Guidance for candidates.

Further reading for trainers and trainer member companies can be found in TACS section 7. -Requirements and guidance for trainers and trainer member companies.

A link to TACS can be found here -
http://irata.associationhouse.org.uk/default.php?cmd=215&doc_id=4193