IRATA SAFETY NOTICE SN16

NEAR MISS: NO KNOTS IN END OF ROPE
PROBLEM WITH ISSOW IN RISK ASSESSMENTS

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Status	Modified member's Safety Bulletin

A member's Safety Bulletin has been simplified and is reproduced for valuable information.

It is unclear how the L1 at the top fitted into the rescue plan. Some relevant IRATA Code of Practice (ICOP) references are inserted in the text below.

1 INCIDENT

1.1 The rope access team consisted of Levels 3, 2 and 1; the L3 and L2 were to conduct outboard visual inspections with the L1 remaining topside as the third man.

1.2 Four sets of ropes were rigged, but upon commencement of the work it was clear that one set of ropes was of no use due to the wind blowing them out of reach. Given the now available working ropes, it was decided that both the L3 and the L2 would work on the same set of ropes to complete the work task. Whilst manoeuvring to the worksite the L2 had asked the L3 if he was to stay on his current set of ropes to which the L3 said "yes". This statement was misinterpreted by the L2 - *what was meant was that the L2 should remain on that set of ropes until the L3 had reached the worksite and then the L2 should transfer to the same set of ropes to which the L3 was attached.* (The L3 having already informed the L2 that they were to work off the same set of ropes, thought that the L2 was aware of the requirement to transfer from his current set of ropes as per the toolbox discussions). (*See ICOP 2.7.2*)

1.3 The L2 then descended on the set of ropes he was on and after 10m-15m his shunt became detached from the bottom of the backup rope. This rope was then out of reach so the shunt could not be reconnected. The L2 then noticed there was no knot in the end of his working rope and now had only 15cm of rope below his Stop descender which was too short to lock the descender.

1.4 The L3 manoeuvred to a position where the L2 could attach himself to the set of ropes he was attached to. This was achieved successfully and the Level 2 descended to the worksite. Both the L2 and the L3 then ascended safely back in-board.

2 ADDITIONAL INFORMATION

2.1 Company 'Safe Working Procedure for Rope Access Operations' states that all ropes should have knots tied at the ends. It is not possible to deploy ropes through gratings with knots in their lower end, so not having tied knots in before the ropes were deployed is not in itself an infringement of procedure. The ropes were correctly deployed through gratings with the appropriate rope protection attached. However, at the earliest opportunity the L3 should have pulled up the ends when in a safe position to do so and tied stopper knots in them. (*See ICOP 2.11.3.9*)

2.2 The site 'ISSOW' (Integrated Safe System of Work) did not identify the hazard of abseiling off the end of a rope which company 'Rope Access Risk Assessment' does.

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It was found that since the implementation of the electronic ISSOW system, our risk assessments have not generally been utilised within the planning stages of work onsite.

2.3 Our risk assessments for activities can be more detailed and all hazards and controls should either be captured within the ISSOW or appended, referred to and used as part of the permit and toolbox talks (*See ICOP 2.11.7.2*) as a safe system of work process. (*See ICOP 2.2*)

2.4 The decision made to work off the same set of ropes is also considered a poor judgement call and added to the confusion in communications. This should only occur in limited situations such as in an emergency. Neither Company nor IRATA documentation recommended this practice.

2.3 The rescue plan that had been discussed lacked sufficient detail and was not entirely understood by all team members. (*see ICOP 2.1.2, 2.2.2, 2.2.5 & 6, 2.11.6.3, 2 11.7.2)*

2.4 The L2 was not entirely sure of what was expected of him, but continued with the job without seeking confirmation or raising his concerns. A team 'Stop for Safety' philosophy should have been implemented when any doubt around the method of access, or a change within the workscope occurred. This would ensure all team members' roles and responsibilities within the team were clear and understood by all.

3 FACTORS CONTRIBUTING TO THE INCIDENT

- Poor Planning (*See ICOP 2.2.2, 2.2.4, 2.2.5*)
- Lack of Clear Communication (*See ICOP 2.11.10*)
- Complacency
- Failure to Follow Procedures
- Failure to apply Rope Access Training

4 ACTIONS TO TAKE/BEING TAKEN

The actions taken following this incident has been identified as:

4.1 Safety Bulletin issued regarding the incident to all sites for lessons learned – please display, roll-out and discuss this at your safety meetings.

4.2 Disciplinary process initiated in accordance with company 'Just Culture' policy.

4.3 Production of 'Safe System of Work' flowchart process outlining where company safety systems fit into clients - particularly risk assessments. (*See ICOP 2.2, 2.2.4*)

4.4 Workshop to identify improvements to Permit System to ensure contractor specialist risk assessments are captured and referred to in system.

In light of this incident, this company encourages others to take a proactive approach to look at how their ISSOW systems ensure the hazards/risk assessments of the specialist activities of their contractors are captured.

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