

Near-miss: improper use of fall-arrest equipment leads to fall

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A Member has reported an incident in which a rigger fell approximately one metre into the sea during rope access work.

What happened?

The rigger was able to climb back up to the fairlead access platform opening. There were no injuries and no emergency rescue was required.

Two riggers were required to remove the pennant wire and clamp from an anchor wire so that recovery of the anchor could continue. The task involved rope access and positioning from the outboard railing using a fairlead access opening to a working platform in order to reach the clamp and pennant wire socket connection (shackle).

The rope access attachment was a 'shark hook' and strop configuration. One rigger selected a strop that provided movement of the connection point so the anchorage point would be under vertical tension. The other rigger selected a shorter strop and one designed to wrap around beams that may have sharp corners. This strop incorporated a one sided rubber liner to protect the integrity of the strop material which also prevented free movement. The final arrangement on this strop had the triangular D-ring adjacent to the choked position. This beam strop and rope access connection was completed from the inboard deck space and not adjusted to the outboard position in a direct line of tension, as should have been done, and the strop was unable to slide around into an ideal position. The rigger using this configuration was applying pressure to the rope access equipment to a position opposite the other rigger, when his shark hook and strop D-ring disconnected causing him to slip approximately one metre into the water.

During the company's investigation the following points were noted:

- An incompatible strop/connector was selected and used as an attachment point (choked around outboard railing). This should not have been permitted.
- The rigger did not check the double action connection was engaged and under vertical tension prior to descending into position.
- There was no dedicated spotter.
- The lanyard connector and anchor point set up enabled 'roll out' to occur through side loading on the primary locking device.
- No secondary safety line was used.

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The company made the following actions and recommendations:

- The type of strop and descending device was changed out before work continued.
- Personnel were briefed on principles of 'dynamic roll-out' and the correct selection of rope access, anchorage points and fall restraint equipment.
- Specialist equipment for 'over the side' work should be purchased as a matched set, clearly identified, inspected and kept together at all times for specific 'over the side' tasks.
- Working at heights awareness training should be a prerequisite for any task requiring the use of fall restraint equipment. Training in rescue equipment and techniques should also be a minimum standard for spotters.

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