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SAFETY BULLETIN NO. 48:
USE OF A TELEHANDLER AS AN ANCHOR

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 A dangerous occurrence took place when ropes were rigged to the forks of a telehandler that had not been immobilized. The telehandler was driven a short distance, to move a compressor, but fortunately no rope access technician was injured.

2 BACKGROUND INFORMATION

2.1 Date of incident: September 2017.

2.2 Injured persons: None.

2.3 Two Level 1 rope access technicians had rigged two sets of ropes to a telehandler. This was checked by the Level 3 supervisor. The technicians were attached to the rigged ropes and had descended the cutting to mark up the rock surface for drilling, as part of some geotechnical works. At the time of rigging the telehandler was locked, no key was present and the driver was away in the site compound.

3 WHAT WENT WRONG

3.1 At approximately 03:20hrs the telehandler driver was contacted to go and reverse the telehandler to attach a compressor. The Level 3 heard the telehandler's reversing beacon and immediately alerted the banksman and driver to stop.

3.2 The telehandler had moved approximately 1m before being told to stop and, as a result, the two rope access technicians attached to the telehandler were pulled upwards.

3.3 One of the rope access technicians was stood near the top of the cutting and was moved a couple of steps upwards. The other technician was situated down the cutting face closer to its base, a short distance above the rail line. He was pulled approximately 0.5m upwards. Once the telehandler was stopped, the rope access technician at the bottom of the cutting descended to the ground and detached from the ropes. The other rope access technician was at the top of the cutting. He walked upwards to the top and detached from the ropes.

3.4 The works were stopped, made safe and a team meeting convened for a site debrief. No treatment was needed as no injury occurred.

4 WHY IT WENT WRONG

4.1 The work had been planned so that the rope access technicians were rigged from their own vehicle (from the road and under traffic management). In this location, due to the position of the parked telehandler, this was not possible.

4.2 The risk assessment and method statements (RAMS) did not state rigging to a third party's vehicle as a method of anchorage. Head office was not informed that the Level 3 on site had changed the documented and agreed method of rigging.

4.3 The Level 3 when deciding to change the method of anchorage did not perform and document changes to the planned method of work.

4.4 The Level 3 did not inform the banksman or telehandler driver before rigging ropes to the telehandler. Neither did he inform any members of the principal contractor's staff.

5 EQUIPMENT

5.1 The banksman and telehandler driver did not perform a 360 degree check of the vehicle before it being moved. If the driver and banksman had performed the correct pre-start vehicle checks before moving the telehandler they would have seen the ropes rigged and no incident would have occurred.

6 DISCUSSION

6.1 This was a high potential near hit. Fortunately, no one was injured. There was certainly a breakdown in communication between the Level 3 and the banksman and driver, both when the ropes were rigged initially and when they arrived at the machine to move it. The correct vehicle pre-use checks were not carried out.

6.2 The procedures set out were not followed by the Level 3 when changing methodology. Change control is an important consideration within a company's processes.

6.3 Vehicles and mobile site machinery of various types can make effective anchors. The vehicle must have sufficient mass and frictional resistance to the ground to provide an unquestionably reliable anchorage for both the working line and the safety line. There should be appropriate attachment points for the anchor lines.

6.4 There should be no possibility that the vehicle engine could be started or that the vehicle(s) could be moved, e.g. by being pushed or by being impacted by another vehicle. Correct isolation of the vehicle(s) should be ensured. Wheel chocking may be necessary. Barricading should be provided to make the vehicle(s) part of an exclusion zone. Signs warning of the dangers of unauthorized movement should be considered. A sentry may be required.

7 REMEDIAL ACTIONS

7.1 The Level 3 supervisor was removed from supervisory duty on this job and issued with a written letter of warning.

7.2 The procedures and RAMS were amended to describe the safe method of work when rigging to vehicles. The member company had not given permission, nor included a safe method of work for rigging from a vehicle.

7.3 A 'learning bulletin' was prepared and disseminated.

7.4 A tool box talk was given to all rope access technicians to brief them on the correct procedures when using vehicles as anchors. All technicians were required to sign to confirm their understanding.

8 FURTHER INFORMATION

8.1 Further information can be found in:

(a) IRATA International code of practice for industrial rope access (Third edition)[1]:

- Part 3, Annex F, Safety considerations when installing or placing anchor devices for use in rope access (Clause F.3.6)

8.2 For a list of current (and past) 'safety communications' by IRATA, see www.irata.org

9 RECORD FORM

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

1 https://irata.org/downloads/2055

IRATA SAFETY BULLETIN – RECORD FORM					
Site:					
Date:					
Topic(s) for discussion:			Safety Bulletin No. 48: Use of a telehandler as an anchor		
Reason for talk:					
Start time:			**Finish time:**		
Attended by *Please sign to verify understanding of briefing*					
Print name:			**Signature:**		
Continue overleaf (where necessary)					
Matters raised by employees:			**Action taken as a result:**		
Continue overleaf (where necessary)					
Briefing leader *I confirm I have delivered this briefing and have questioned those attending on the topic discussed.*					
Print name:		**Signature:**		**Date:**	
Comments:					