

Doc. No.: HS-385ENG	<h1>IRATA</h1> <h2>Safety Bulletin No. 51</h2>	
Date of Issue: 08/04/2025		
Issue No.: 002		
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SAFETY BULLETIN NO. 51: DROPPED AND FALLING OBJECTS

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.

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This safety bulletin - including, where given, any conclusions - is not as a result of any investigation undertaken by IRATA. The case study 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.

1 INTRODUCTION

Dropped and Falling Objects within this safety bulletin, refer to any object(s) that falls unexpectedly, resulting in or having the potential to result in a negative consequence (incident, near miss, or dangerous occurrence).

Although dropped object prevention has long been the focus of safety campaigns by IRATA International and the work at height sector, incidents continue to occur as a result of Dropped or Falling Objects.

1.1 Definitions

Dropped Object any object physically released from an active control method that prevented it from immediately falling, or falling out of a sealed container, e.g. holding a tool and letting it go, a tool tether failing, thus releasing the tool, or a tool falling out of an unsealed container

Falling Object any object released from an inactive/passive control method which prevented it from falling and resulted in its uncontrolled descent, e.g. a board held in place by its own weight blown from a roof, or a rock dislodged by a rope

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2 FALLING OBJECT - CASE STUDY 1

Case Study 1

During the rope access team's operations in a light well, a third-party entered the rigging area and began moving scaffold clips. The third-party team had placed a scaffold clip next to a set of ropes which were in use by the rope access team below.

A technician working on a ledge 5 metres below adjusted his position, which shifted the ropes above and dislodged the scaffold clip, causing it to fall and strike the wrist of the technician below, resulting in a fracture, major bruising and some minor lacerations.

The technician was able to abseil down to the landing below with assistance from a team member working next to him. The technician was then taken to hospital and treated. The injury resulted in 7 weeks off work.

This incident was caused by a third-party placing the scaffold clip in a position where it could be easily dislodged, resulting in the Falling Object striking a technician and causing a major "Over 7-day injury".

2.1 Why Did This Happen?

Works were allowed to continue in the rigging area with no exclusion zone or procedural controls. The risk of Dropped or Falling Objects from third-party operations had not been assessed or controlled.

There was no supervisor or sentry present in the rigging area. As a result of this, the third-party working above was unaware of the works being undertaken below them and the potential risks associated with Falling or Dropped Objects.

2.2 What Could Have Happened?

The technicians were working 5 metres below the area where the scaffold clip was placed. The clip weighed just under 1kg, and the consequences of impact from this height could have been life changing or potentially fatal.

2.3 What Should Have Happened?

- a) Procedures should have been in place to control any works above the technicians.
- b) An exclusion zone should have been set up and if necessary supervised to prevent any unauthorised access to the rigging area.
- c) A comprehensive risk assessment should have been conducted to control the risks of Dropped or Falling Objects from above.

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3 DROPPED OBJECT – CASE STUDY 2

Case Study 2

A rope access technician working in the city received a telephone call from one of the other rope access team members. The technician had been using the phone throughout the works to take photographs of the damaged areas of the buildings glazing. During these works the phone was attached to a manufactured tether specifically to prevent it being dropped.

During the call the technician stopped work and removed the phone from the tether to be able to hold it to his ear whilst having the conversation. At the end of the phone call the technician put the phone back into his pocket but failed to close the zip. When he raised his leg to reposition himself, the phone fell out of his pocket, and it dropped 60 metres onto the road below hitting and smashing a parked car windscreen outside of the exclusion zone.

3.1 Why Did This Happen?

The technician had removed the phone from its tether and then had not zipped up his pocket to prevent the phone falling out.

The dropped object risk from the mobile phone had not been correctly controlled.

3.2 What Could Have Happened?

Falling from a height of 60 metres, the mobile phone could have struck a person causing potentially serious injury or a fatality.

If the vehicle hadn't been stationary and unoccupied at the time of the impact, this could have resulted in a road traffic accident, causing multiple injuries or a fatality.

3.3 What Should Have Happened?

- a) The technician should not have removed the phone from its tether.
- b) When not in use the phone should be stored correctly to prevent it being dropped.

Note: This example demonstrates an active control being removed (the tether) and a passive control failing through misuse (the pocket not being zipped up).

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4 USEFUL CONSIDERATIONS

To prevent incidents caused by Dropped and Falling Objects, a combination of active and passive controls should be considered/utilised. Most of these types of incidents occur as a result of something being accidentally dropped or dislodged rather than by a deliberate action.

During rope access operations it is difficult to eliminate every risk of Dropped or Falling Objects, so it is important to consider the various control methods available to help prevent this resulting in an incident.

Examples of control measures are listed in the table below;

Control Measure Type		Control Measure
Active	Passive	
Yes		Prefabricated tool tether - Specifically designed and manufactured for its intended use. These tethers will normally include information on the weight limit, use, inspection and limitations of the tether.
Yes		Constructed tool tether – Usually constructed from accessory cord and tied to enable connection to tools and equipment. Other components such as karabiners are used for connection with each component having its working load limits. It is important that any constructed tether is made by a competent person using appropriate materials/components for its intended use.
Yes		Tool tethering tape – Usually self-amalgamating tape which can be used to fix a connection point to a tool.
Yes		Tool pouches/holsters – usually fitted to removeable tool parts such as batteries to allow them to remain connected during a changeover.
Yes		Additional securing connections – Usually additional safety straps. Some tools and materials are supported at height by non-mechanical means such as magnets or suckers, consider using additional means of connection in case of primary connection failure.
Yes	Yes	Pod bags/bucket bags/sealable containers – There are many variations of these which may have pockets, zips, magnets, tethers and tethering points. These should be sealable to prevent objects dropping out when moving.
	Yes	Debris nets – Usually installed in a type and manner suitable to catch and restrain any objects which may be dropped or fall into it.
	Yes	Crash decks – Usually constructed from scaffold tube and boards. Designed and constructed by relevant competent qualified persons.
	Yes	Debris catch bags - Specifically designed and manufactured for their intended use, these will normally include information on the weight limit, use, inspection and limitations of the bag.
	Yes	Exclusion zone – Must be suitable for its intended use and normally used in conjunction with any of the above examples.
	Yes	Drop mats/grid mesh – Usually used when working on steel grate or grid mesh flooring as a covering to prevent objects falling through the gaps.
	Yes	Toe-boards/kick plates/boards – Usually fitted to scaffold, stairs and handrails to prevent objects rolling off a structure and falling.

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Control Measure Type		Control Measure
Active	Passive	
	Yes	Foreign material exclusion/procedural controls – Working procedures used to ensure materials do not get into places where they should not be or can potentially be dropped, e.g. empty pockets and no unnecessary tools or equipment allowed in an area.
Yes	Yes	Training and information – Provided to personnel on the risks, hazards and controls associated with Dropped and Falling Object prevention. Candidates and technicians being informed during IRATA training to zip up pockets or keep them empty.
Yes	Yes	Suitable storage of equipment and materials – Ensure all materials and equipment stored at height are secured to prevent them from falling.
	Yes	Inspection, maintenance and correct use of equipment – Any equipment used to prevent objects from falling or being dropped are critical for safety and must be inspected and maintained to ensure they are fit for purpose and used in the correct way.
	Yes	Potential dropped object survey – Check the work area before the works commence and ensure it is clear of potential Dropped Objects when work is complete. Common examples are tools, unused fixings and scaffold clips left on steelwork.
	Yes	Procedures and methods of work – Wherever possible do not work in a position where there is a possibility of being under a Dropped or Falling Object, e.g. removing loose material from the top down and not working underneath other people or operations that present this risk.

Note: An effective exclusion zone below the works should not be the only control method used but may be the one which makes all the difference. We cannot always control Dropped Objects, so we must control what is below them.

5 ADDITIONAL INFORMATION

5.1 References

FM-323ENG	IRATA Prevent Dropped Objects Poster
HS-091ENG	IRATA Topic Sheet No. 11 - Dropped Objects
HS-095ENG	IRATA Topic Sheet No. 15 - Tool Lanyards
HS-431ENG	IRATA Topic Sheet No. 31 - Tool Tethering and Lanyards

5.2 Additional Links

- DROPS (Dropped Objects Prevention Scheme) <https://www.dropsonline.org/>
- ANSI Dropped object prevention solutions <https://webstore.ansi.org/standards/isea/ansiisea1212018?srsId=AfmBOopQXQns-j6-E1j0UWPuf58FM7GHaRIVtlgvT9pY-sdaDV-9UQFt>

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6 RECORD FORM

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

IRATA SAFETY BULLETIN – RECORD FORM			
Site			
Date			
Topic(s) for discussion	Safety Bulletin No. 51: Dropped and Falling Objects		
Reason for talk			
Start time		Finish time	
Attended by <i>Please sign to verify understanding of briefing</i>			
Print name	Signature		
<i>Continue overleaf (where necessary)</i>			
Matters raised by employees	Action taken as a result		
<i>Continue overleaf (where necessary)</i>			
Briefing leader <i>I confirm I have delivered this briefing and have questioned those attending on the topic discussed.</i>			
Print name		Signature	Date
Comments			