

WORK & SAFETY ANALYSIS 2024



ABSTRACT

This summary report presents key data submitted by members of the Industrial Rope Access Trade Association (henceforth referred to as IRATA) for the period January 2023 to December 2023.

Recommendations are made relating to:

- accident and incident reporting;
- common themes;
- recent recommendations;
- 'behavioural competence' and 'safety culture';
- 'leading' and 'lagging' indicators;
- 'human failure' and 'human factors';
- data collected.

Appendix I provides the Glossary of Terms Used and some regional data is provided in Appendix II. The full report is available at www.irata.org.

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Retired. UK Health and Safety Executive (1997 to 2007). Director and Company Secretary, UK Temporary Works Forum (2014 to 2023). Member, BSI Technical Committee, PH/5, Personal Fall Protection (1998 to 2022) and, later, Chair (2008 to 2022).

Awarded Individual Life Membership of IRATA in recognition of service to the association and the rope access industry (2007).

Awarded the Garth Watson Medal by the Institution of Civil Engineers for dedicated and valuable service to temporary works and the civil engineering industry (2023).



“... wherever you are in the rope access industry, go and start a ‘safety conversation’ ...”



Image courtesy of MIRA Rope Access © 2024

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1. INTRODUCTION

This summary report presents key employment, accident and incident data submitted by members of IRATA for the period January 2023 to December 2023¹. Some discussion and recommendations are included.

NOTE: Data presented in square brackets thus [604] represents data from the previous year, 2022.

“The only real mistake is the one from which we learn nothing”

Source: Henry Ford

2. IRATA MEMBERSHIP & EMPLOYMENT STATISTICS

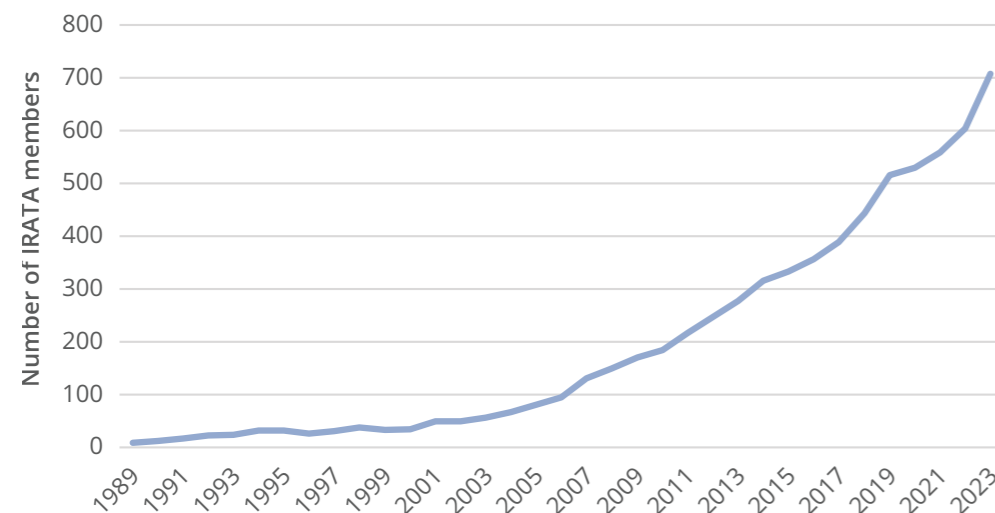
2.1 MEMBERSHIP

The number of members at Q4 2023 was 708 [604] (see **Figure 1**). This is an increase of 17.2% over the last year and 37.2% over the last 5 years. Of the 679 reporting members² 88 companies reported an accident or incident.

“Plan-Do-Check-Act (PDCA)”

Attributed: W. Edwards Deming

Figure 1 : IRATA membership numbers at Q4 2023



1 See Guidance to IRATA Work and Safety Statistics Return, GU-022 v009

2 Excludes associate members.

2.2 EMPLOYMENT

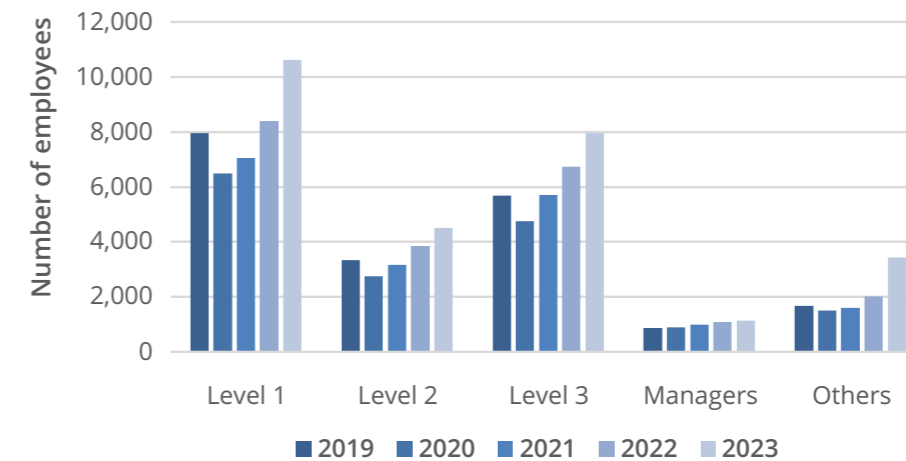
Total employment in 2023 averaged 27,669 [22,076] (see **Figure 2**). This is an increase of 25.3% over the last year and 41.7% over the last 5 years.

Notable is the 26.7% increase in Level 1s from 2022 to 2023 - 10,629 [8,389]

26.7%

Increase in Level 1s from 2022 - 2023

Figure 2 : Distribution of employment between grades

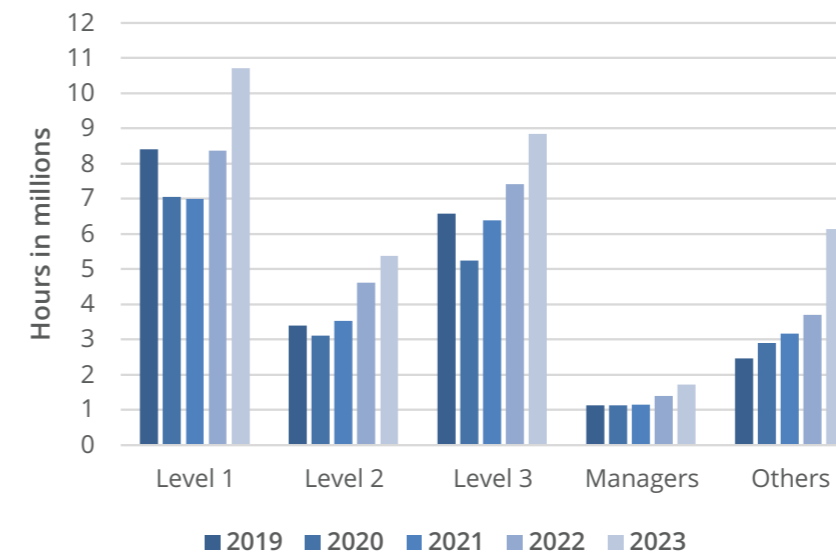


2.3 REPORTED HOURS WORKED

The distribution of reported work hours by grade is shown in **Figure 3**. The total hours worked in 2023 is 32,795,726 [25,501,640], this is an increase of 28.6% from 2022, and 49.2% increase over the last 5 years.

Notable is the in-year increase in 'Others' at 66.2% and Level 1s at 28.0%. The 'full time equivalent' (FTE) workforce is 16,398 [12,751]. The split between those grades working onshore and offshore is not recorded.

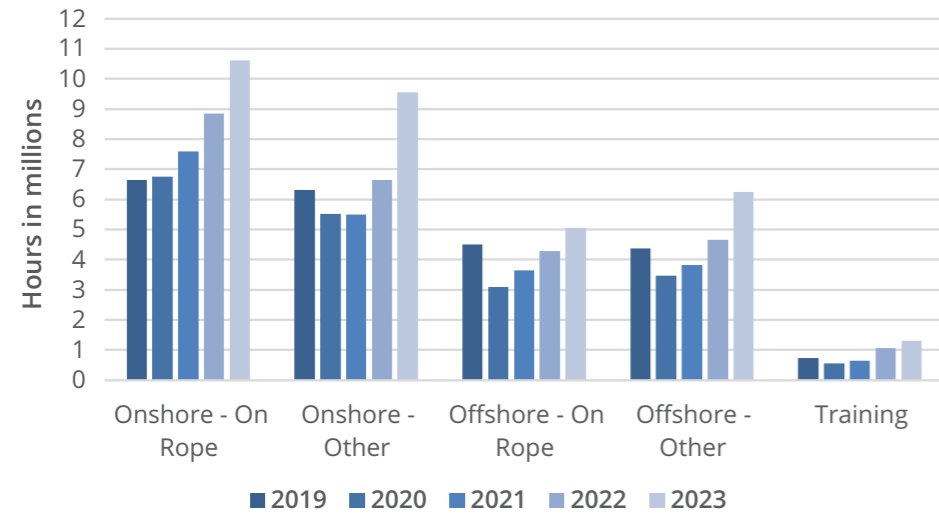
Figure 3 : Distribution of reported work hours by grade



2.4 LOCATION OF HOURS WORKED

The work hours are shown distributed between offshore and onshore working and training (see **Figure 4**). Excluding 'Training', the ratio of onshore to offshore is 0.64 to 0.36.

Figure 4 : Location of hours worked



2.5 TRAINING

The number of training hours reported by members is 1,306,195 [1,062,549], see **Figure 5**. This is an increase of 22.9% over the last year and 77.6% increase over the last 5 years.

77.6%

increase in reported training hours over the last 5 years.

Figure 5 : Training hours by year

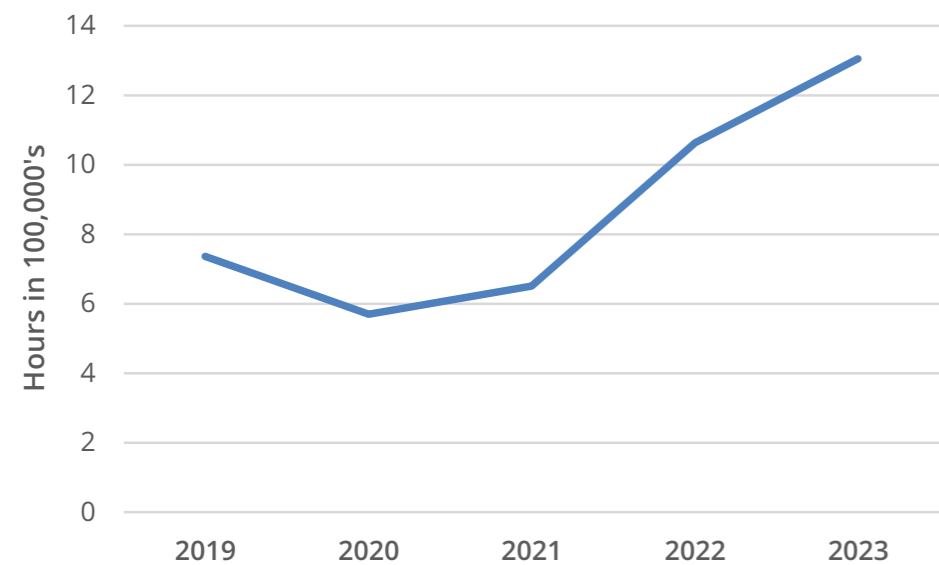


Image courtesy of ABSAFE © 2024

3. ACCIDENT AND INCIDENT STATISTICS

NOTE: There is variation in the legislative requirements for reporting accident data worldwide. See **Appendix I** for an explanation of the terms used by IRATA for 'Fatality' and 'Major' injury ('Serious') as well as 'Over 7-day' injury, 'Less than 7-day' injury, 'Incident' and 'Near Miss'.

3.1 INTRODUCTION

A total of 356 [321] reports were received. This equates to just 0.5 report per member. This ratio has been broadly consistent over recent years. In summary: total number of reported incidents, 356; not relevant, 5; training 'errors' with no injury, 84; remainder for analysis, 267. Of the 267 accidents and incidents

analysed, 124 reports were linked to 7 companies (46.4%). These 7 companies account for 4.78% of all hours worked but report 46.4% of all incidents. Whether this is typical of a long-term trend is not known.

3.2 DISTRIBUTION OF ACCIDENT AND INCIDENT REPORTS

The distribution of accident and incident reports is shown in **Figure 6**. Notably, 40.4% (108) of reported accidents and incidents are not 'On Rope'. It is noted that for every 1.0 incident reported 'Offshore' there are 8.2 'Onshore'.

For every incident reported 'On Rope' there were 1.93 'Other'.

The variation in the level of reporting between Regional Advisory Committees (RACs) is large. Globally, it is considered likely that different approaches are

taken to risk management and improving safety culture³. It is considered also that the role of accident and incident reporting is not always appreciated. Some organisations may doubt the need to share the underlying causes and thus do not learn effectively from failure. However successful an organisation, it is hard to accept that even a 'Near Miss' is never reported. A robust reporting culture is considered essential.

NOTE: Some regional data is provided in Appendix II

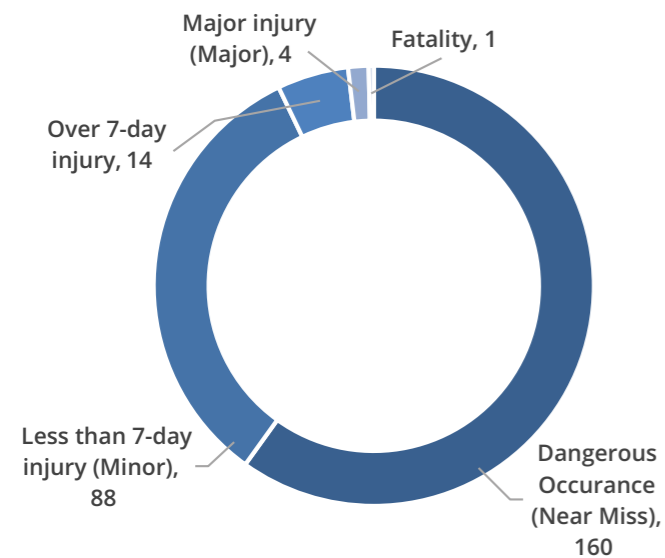


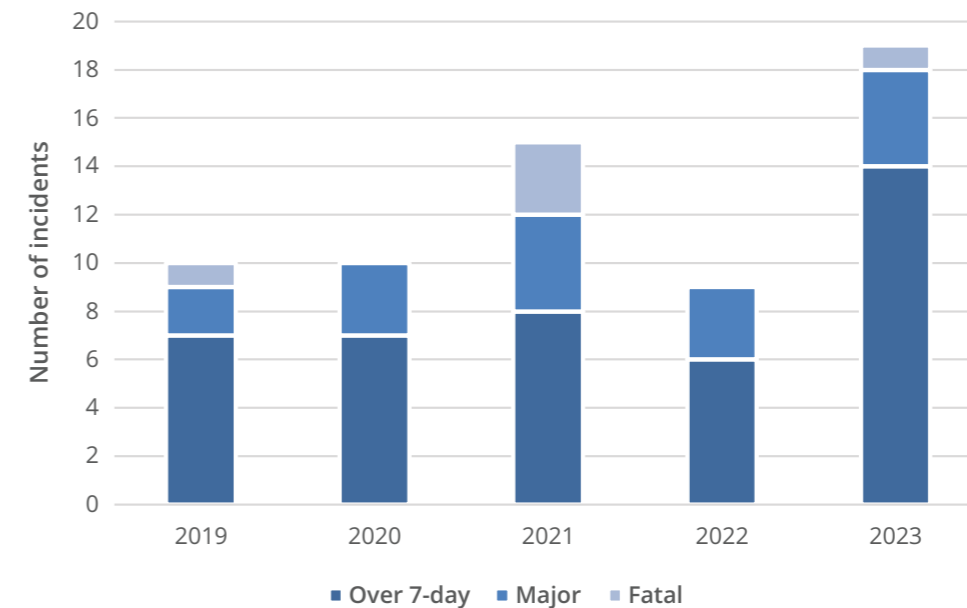
Figure 6 : Distribution of accident and incident report

3 Measuring the safety climate in organisations: Reduce injuries and costs through cultural change, https://books.hse.gov.uk/gempdf/Measuring_the_Safety_Climate_in_Organisations.pdf (HSE)

3.3 ACCIDENT AND INCIDENT DATA OVER TIME

The accident and incident data over time for 'Fatal', 'Major' and 'Over 7-day' injuries are shown in **Figure 7**.

Figure 7 : 'Fatal', 'Major' and 'Over 7-day' injuries



The number of reports covering 'Fatal', 'Major' and 'Over 7-day' injuries was 19 in 2023 [9]. Sadly, this figure includes a fatality. The number of 'Over 7-day' injuries was 14 in 2023 [6], compared to the in-year total of 19. The 5-year average is 8.4.

The accident and incident data over time for 'Less than 7-day' ('Minor') and 'Near misses' is shown in **Figure 8**.

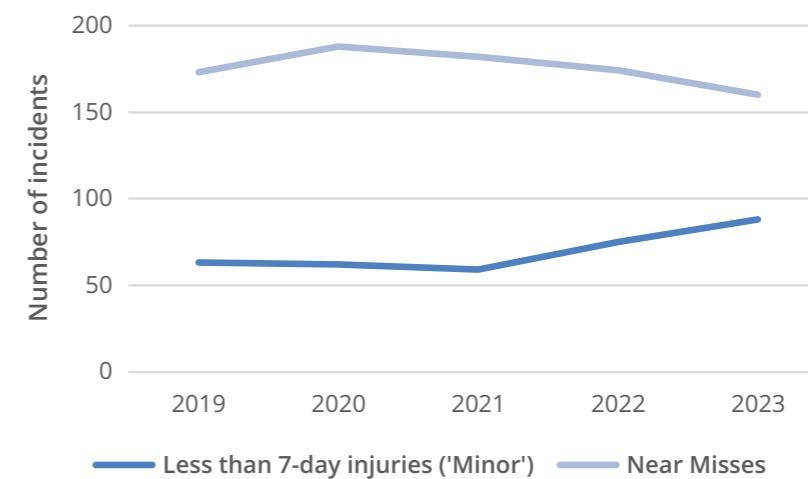
.....

19

'Fatal', 'Major' and 'Over 7-day' injuries

.....

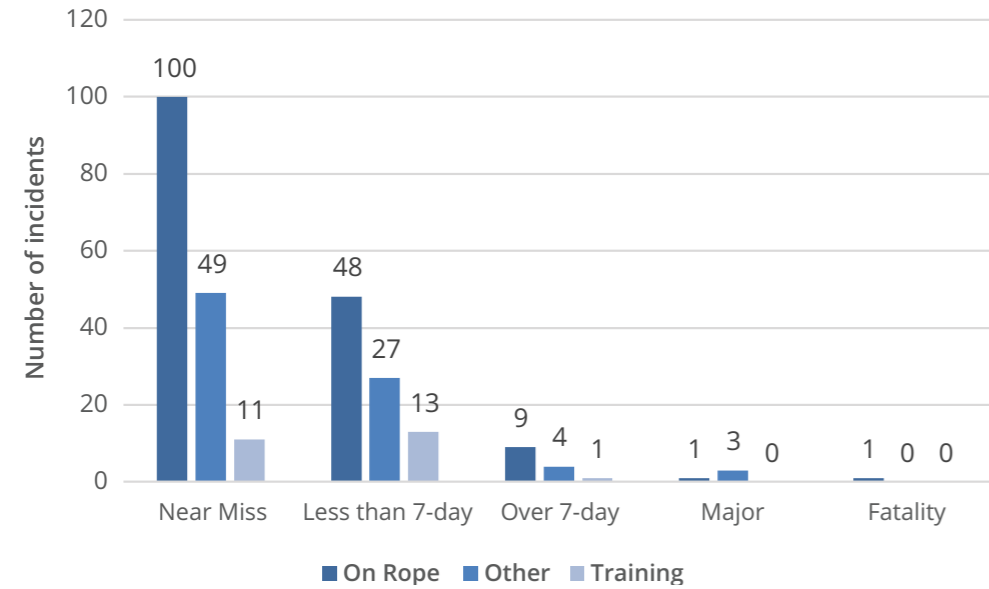
Figure 8 : Less than 7-day injuries ('Minor') and 'Near Misses'



3.4 SUMMARY OF REPORTED ACCIDENTS AND INCIDENTS IN 2023

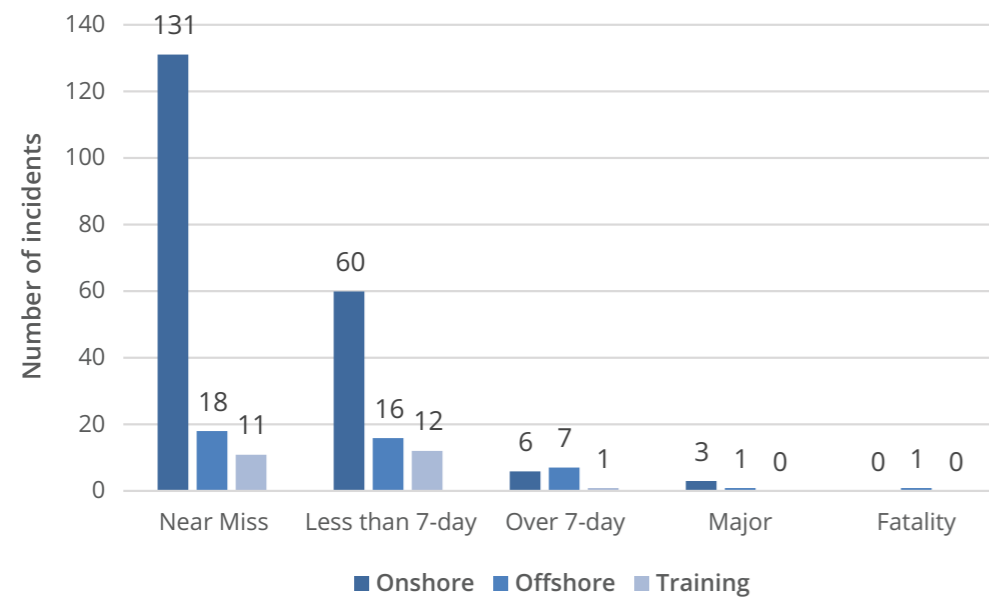
In summary, the reported accident and incident data by activity in 2023 is shown in **Figure 9**:

Figure 9 : Reported accident and incident data by activity



Alternatively, by location, see **Figure 10**:

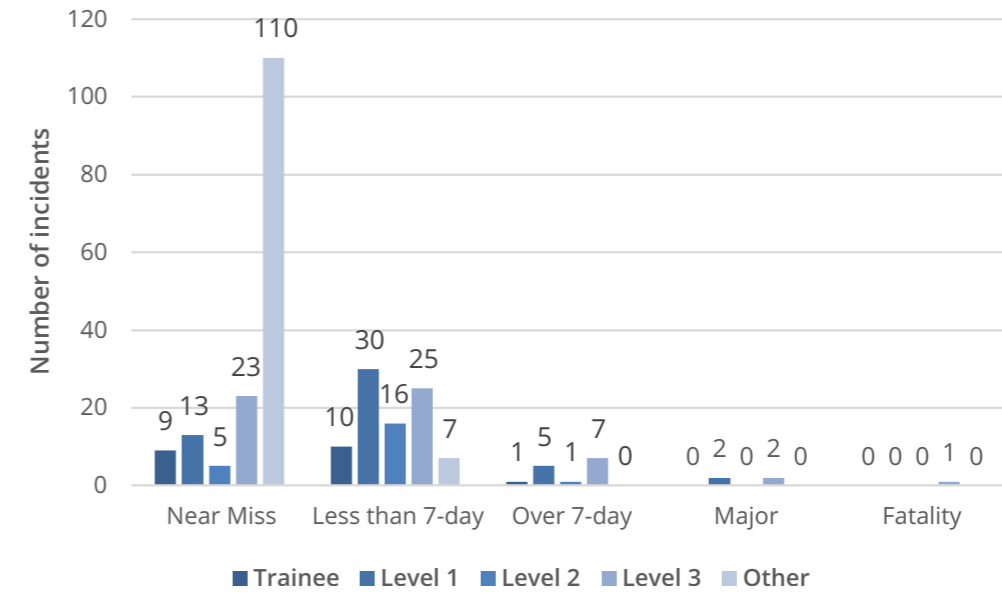
Figure 10 : Reported accident and incident data by location



Alternatively, by grade, see **Figure 11**. Many reported 'Near Misses' are to the grade 'Other' (110, 68.8%). The reason for this is not clear.

68.8% 'Near Misses' reported to the grade 'Other'

Figure 11 : Reported accident and incident data by grade



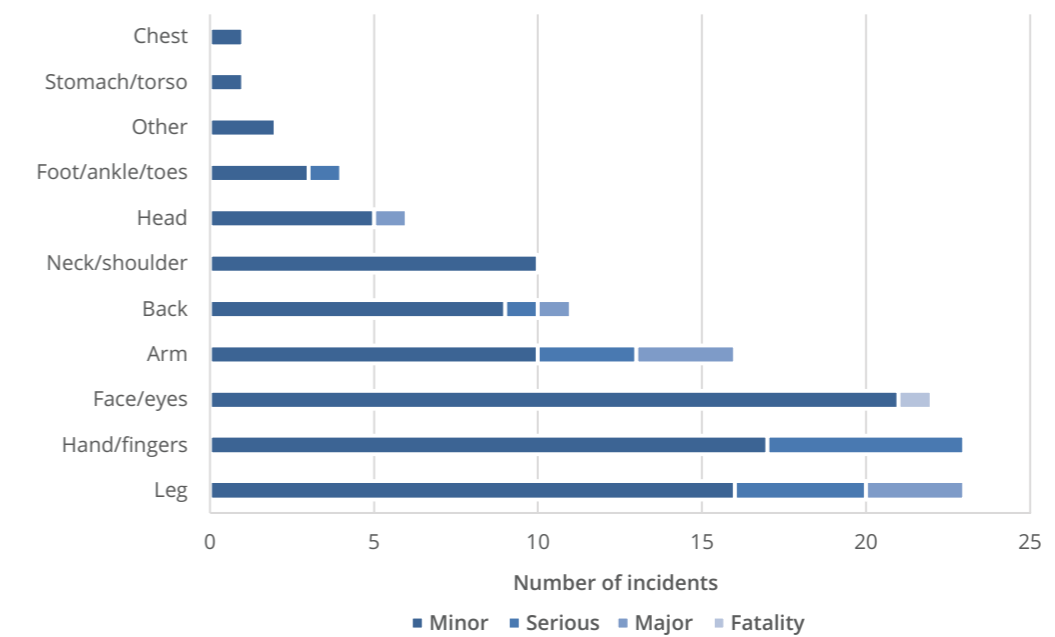
3.5 BODY PARTS INJURED

The number of injuries by body part in 2023 is 119 [94], see **Figure 12**. This is based on 115 incident reports. The total number of injuries is not equal to the number of reports as multiple injury sites are sometimes reported.

119

The number of injuries to body parts in 2023

Figure 12 : Body part injuries



3.6 IMMEDIATE CAUSE OF ACCIDENTS AND INCIDENTS

NUMBER OF REPORTS

This review is based on 266 incident reports. Some reports were associated with more than one 'cause'. The largest totals were:

- Operator error or omission (61)
- Falling or dropped object (46)
- Contact with tool(s), material or equipment (50)

Looking at 'Other' (20) this includes:

- Third-party entering exclusion zone (2)
- Wind weather (10)
- Unidentified equipment (1)
- PPE damaged (1)
- Near miss with support vessel (1)
- Member of public being dangerous (1)
- Wild animal (2)
- No PPE (1)
- Contamination (1)

WEATHER

In turn, 'wind weather' (10) includes:

- Eye injuries from wind blowing particles around the correct PPE (6)
- Wind blowing loose cladding into face (1)
- Wind blowing slag from welding onto a technician (1)
- Change in weather causing ice to fall (1)
- Wind causing a door to slam catching the technician's hand (1)

It is recommended that consideration be given to adding 'Weather' as a cause.

LOW PROBABILITY/HIGH CONSEQUENCE EVENTS

The following causes are low in total number and might therefore be assessed as 'low risk'. However, the consequences of failure are high:

- Rope access equipment malfunction (4)
- Rope access equipment failure (6)
- Failure of a permit to work system (8)
- Rope damage (16)

Focus should remain on these issues, some of which recur year on year.

COMMON THEMES

A qualitative assessment of the descriptions provided by members in their incident reports identifies several areas of note. In respect of these issues at least it is recommended that members review their training and procedures to take the following into consideration:

- Falling or dropped objects
- Ice
- Ill-health
- Musculo-skeletal
- Pipes
- Rope damage
- Wind turbines



3.7 MANAGEMENT FACTORS

The number of accidents and incidents reported (267) as having 'Management' as an underlying cause is 130, identifying 169 reasons (some reports had multiple reasons). See **Figure 13**.

Recurring themes include:

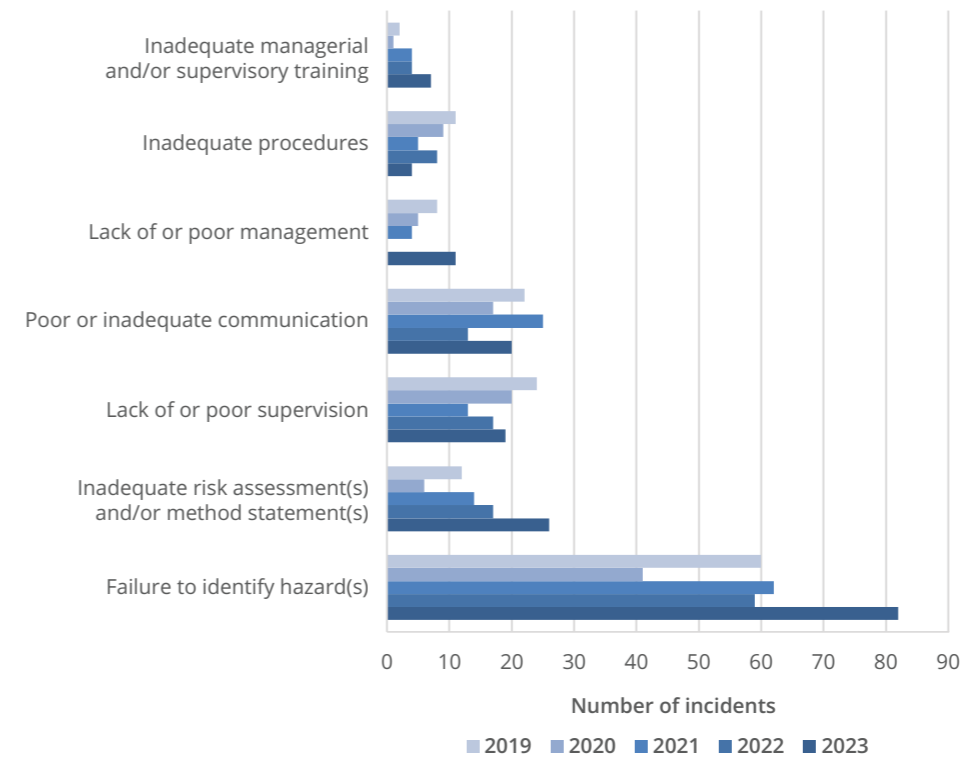
- failure to identify hazard(s)
- inadequate risk assessment(s) and/or method statement(s)

Interestingly, 137 reports list 'human factors' as 'not applicable' (see **Para. 3.11**). This number appears high. It is suggested that there is a greater proportion of underlying management deficiencies.

137

reports list 'human factors' as 'not applicable'

Figure 13 : Management factors



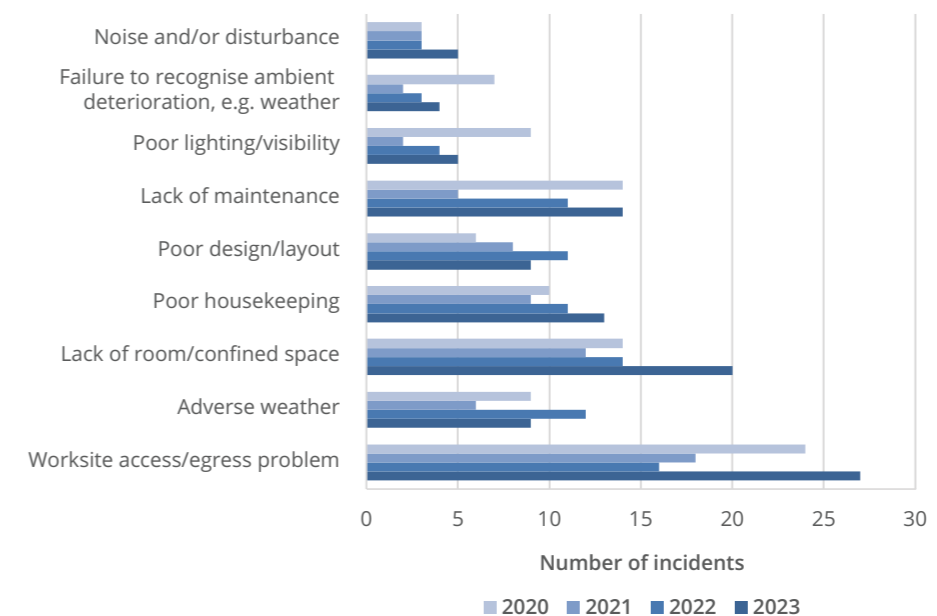
3.8 WORKING ENVIRONMENT

The number of accidents and incidents reported (267) as having 'Working environment' as an underlying cause is 99, identifying 106 reasons (some reports had multiple reasons). See **Figure 14**. The overall trend is broadly level.

99

accidents and incidents reported as having 'Working environment' as an underlying cause

Figure 14 : Work environment

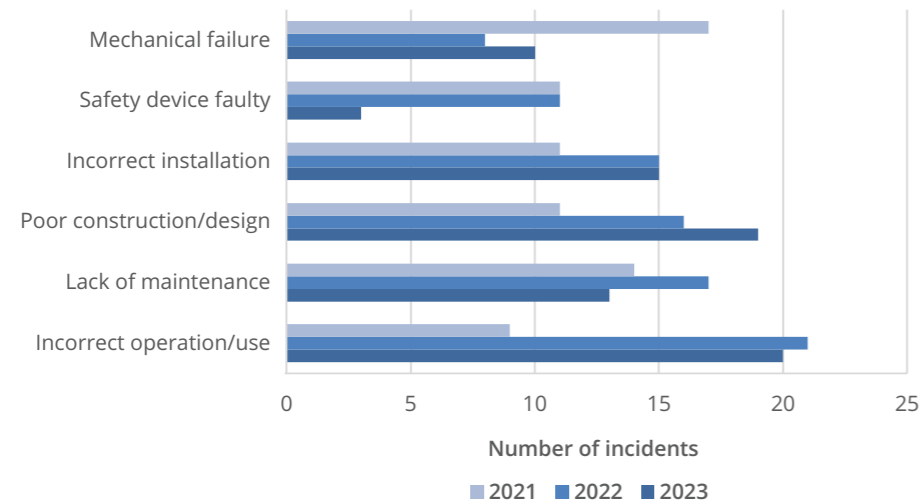


3.9 PLANT AND/OR WORK EQUIPMENT

The number of accidents and incidents reported (267) as having 'Plant and/or work equipment' as an underlying cause is 62, identifying 80 reasons

(some reports had multiple reasons). See **Figure 15**. The overall trend is broadly level.

Figure 15 : Plant and/or work equipment



3.10 PERSONAL PROTECTIVE EQUIPMENT (PPE)

The number of accidents and incidents reported (267) as having PPE as an underlying cause is 57. See **Figure 16**. The overall trend is downwards. There has been a drop in the overall number of occurrences (in particular, 'Incorrectly used' and 'Defective').

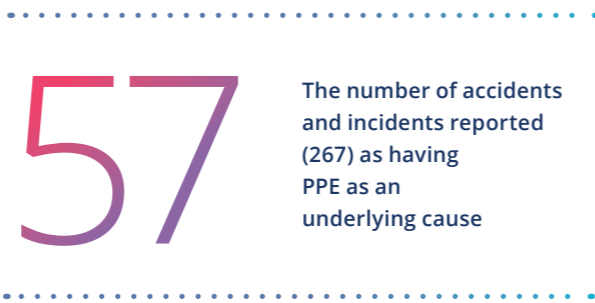
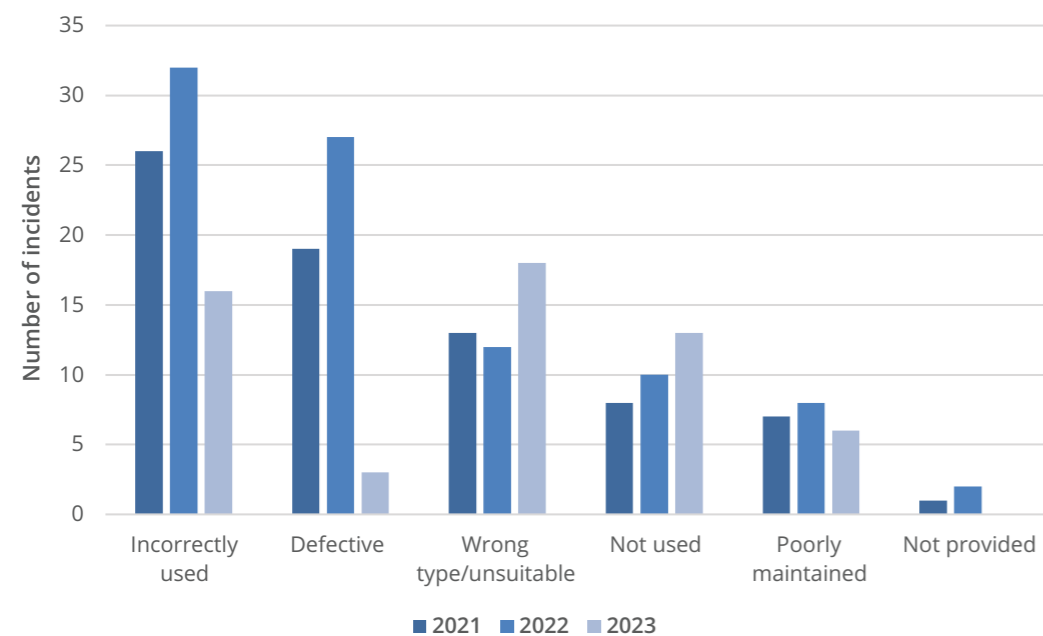


Figure 16 : Personal protective equipment (PPE)



3.11 HUMAN FACTORS

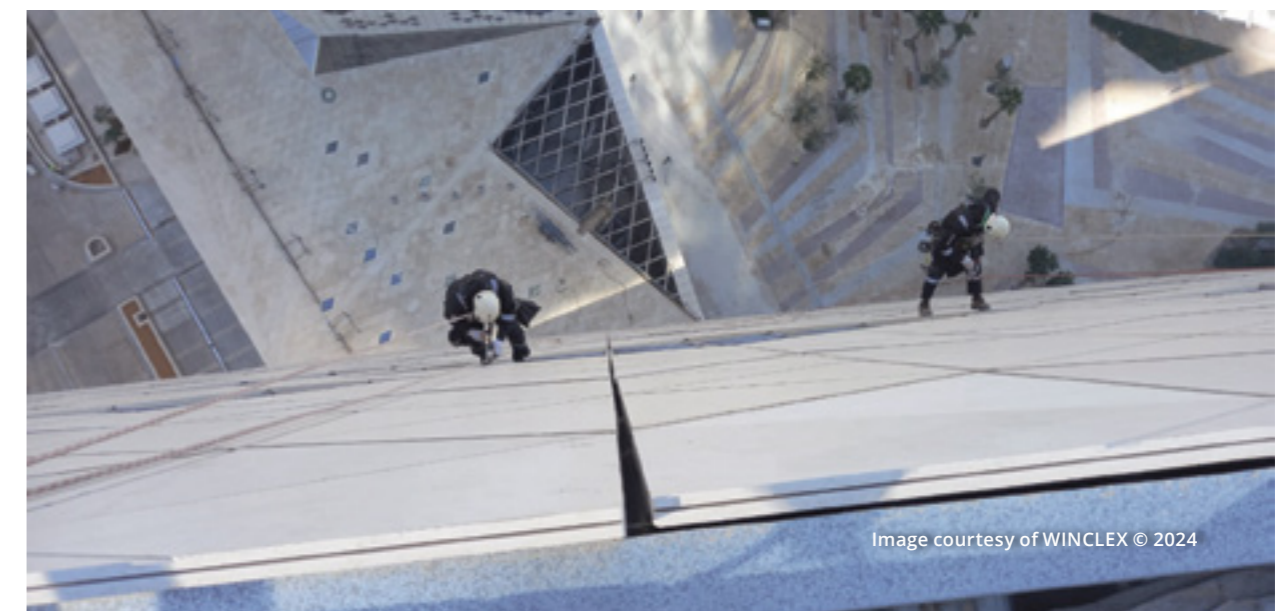
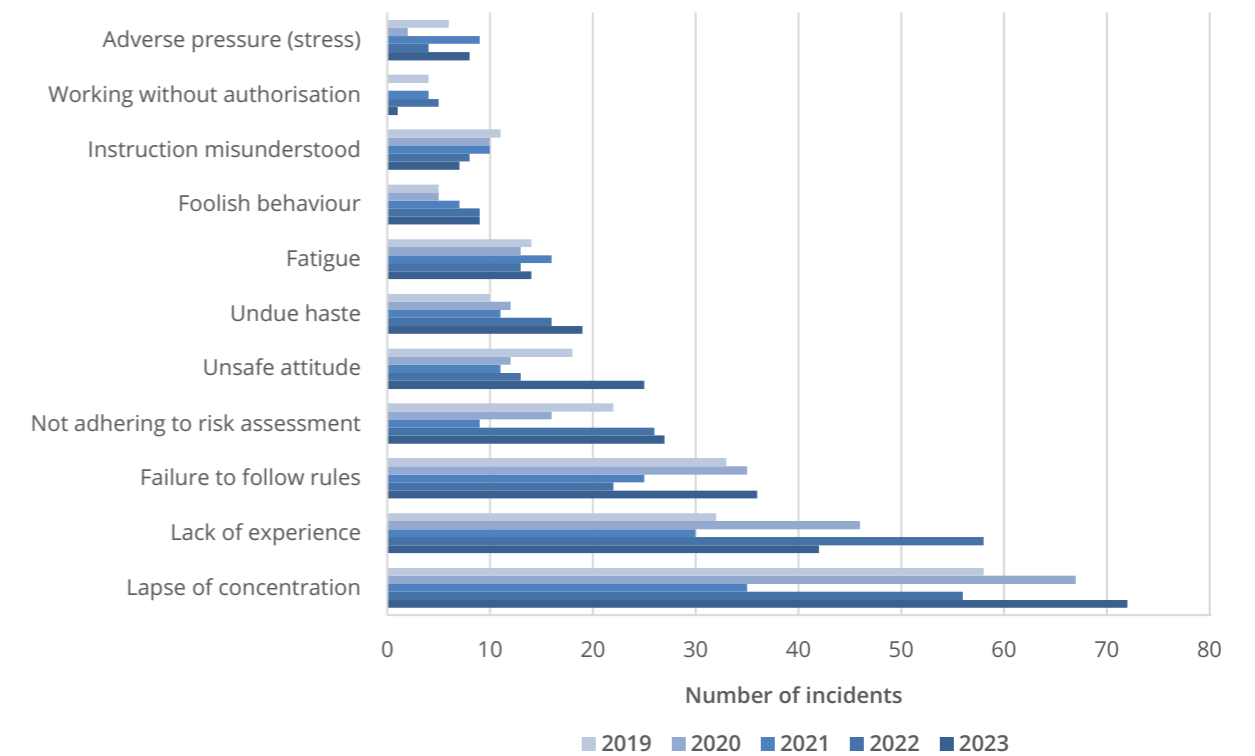
The number of accidents and incidents reported (267) as having 'Human factors' as an underlying cause is 242. See **Figure 17**. There has been an increase in 'Lapse of concentration' to 72 [56].

accountability). There can be a tendency for managers to blame workers.

This report records a low number of 'management factors' (**Para. 3.7**) compared to a higher number of 'human factors' (**Para. 3.11**). What constitutes 'safety culture' is ripe for a discussion amongst IRATA membership as well as what motivates better incident reporting.

A key consideration in a good safety culture is the existence of a 'just' culture (in lieu of the often-prevailing attitude and culture of 'blame'). Organisations should move from a blame culture to a just culture (and one of

Figure 17 : Human factors



3.12 NON-INJURIOUS TRAINING ERRORS

This category of data was introduced in 2022.

See **Figure 18**.

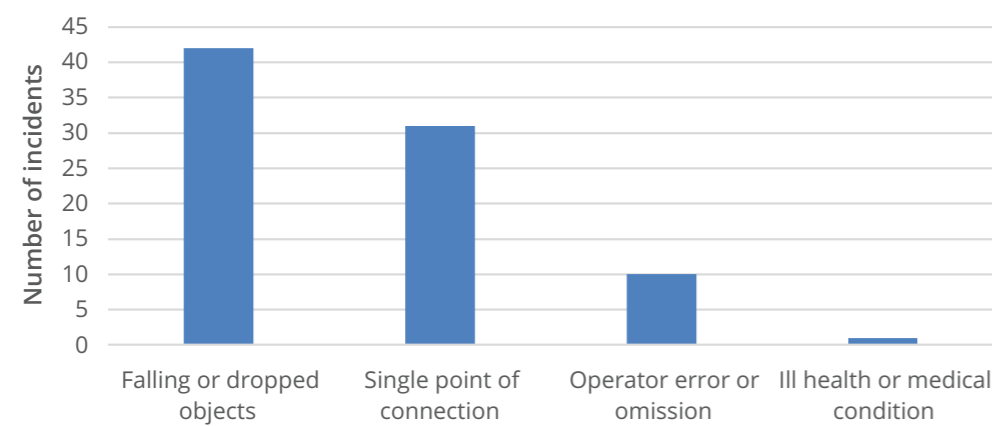
A limited number of training companies have submitted reports. There are 300 Trainer Member Companies, for unknown reasons it appears that data is not being collected routinely. Of the 84 reported incidents, 82 are from one member (and their commitment should be applauded), i.e. just 3 companies submitted training incidents. Accordingly, the data is not considered representative of the association as a whole, or of the Trainer Member Companies.

It is suggested that:

- (i) Trainer Member Companies are not aware of the need and/or importance of learning and sharing; and/or
- or
- (ii) the categories need reconsidering (e.g. KPI(s) based on formal assessment results, for example).



Figure 18 : Non-injurious training errors



Response from IRATA

This year IRATA has updated their incident reporting procedure and the member incident reporting guidance to clarify the information required from its Trainer Member Companies.

This change clarifies that incidents occurring during IRATA training which would be considered as discrepancies during an assessment, e.g. the categories provided in the table above, would not need to be reported as they are occurring in a safe environment and may be expected to occur during training.

Whereas incidents that do or could result in injury (e.g. a fall from height, uncontrolled swing or ill health) are to be reported.

The incidents that are no longer required to be reported during training are captured during assessment and operational works, enabling IRATA to continue monitoring these occurrences and react appropriately.

4. RISK DATA

“If you can’t explain it simply, you don’t understand it well enough.”

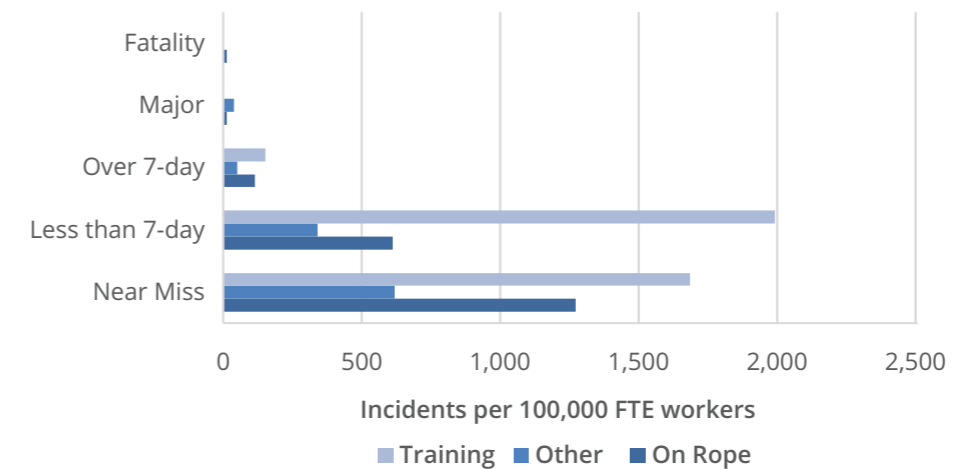
Source: Albert Einstein

4.1 RISK BY ACTIVITY

Taking the accident and incident data by activity and the hours worked the risk by activity is shown in **Figure 19**.

Note: Full-time equivalent (FTE), is a unit of measurement that indicates the workload of an employed person in a way that makes workloads comparable across various contexts.

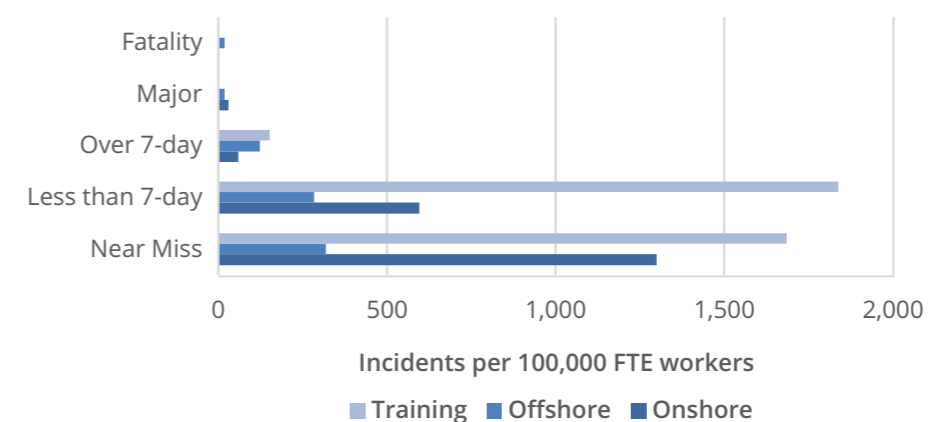
Figure 19 : Risk by activity (per 100,000 workers, FTE)



4.2 RISK BY LOCATION

Taking the accident and incident data by location and the hours worked the risk by location is shown in **Figure 20**:

Figure 20 : Risk by location (per 100,000 workers, FTE)



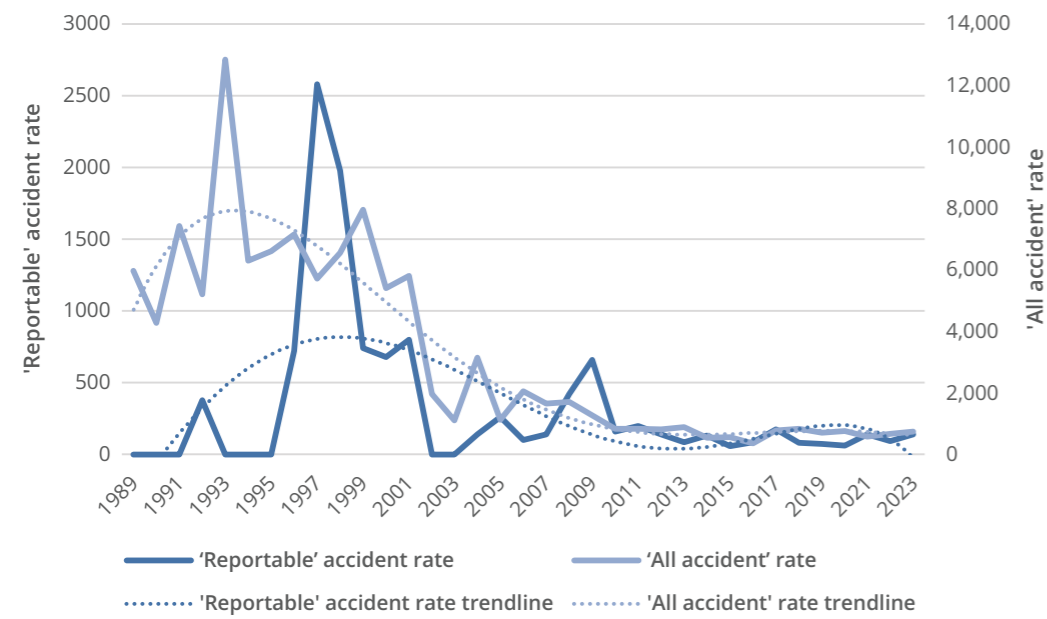
4.3 ACCIDENT RATE FOR 'ON ROPE'

Figure 21 shows the accident rate for 'On Rope' between 1989 and 2023. This indicates that both the On Rope 'reportable' rate and the On Rope 'all accident' rate have broadly been on a plateau for several years.

No comparison is made with global data. It is recommended that 'benchmarking' be researched to determine current good practice.

For comparative purposes, perhaps just for the last (say) 5-years, it would be useful to include 'Off Rope' and 'Other'. Thus, giving the often used Total Recordable Injury Rate (TRIR) and/or Lost Time Injury Rate (LTIR).

Figure 21 : Accident rate for 'On Rope'



The recent breakdown of 'On Rope' 'Reportable accidents' is shown in **Figure 22**:

Figure 22 : Breakdown of 'Reportable accidents' ('On Rope')

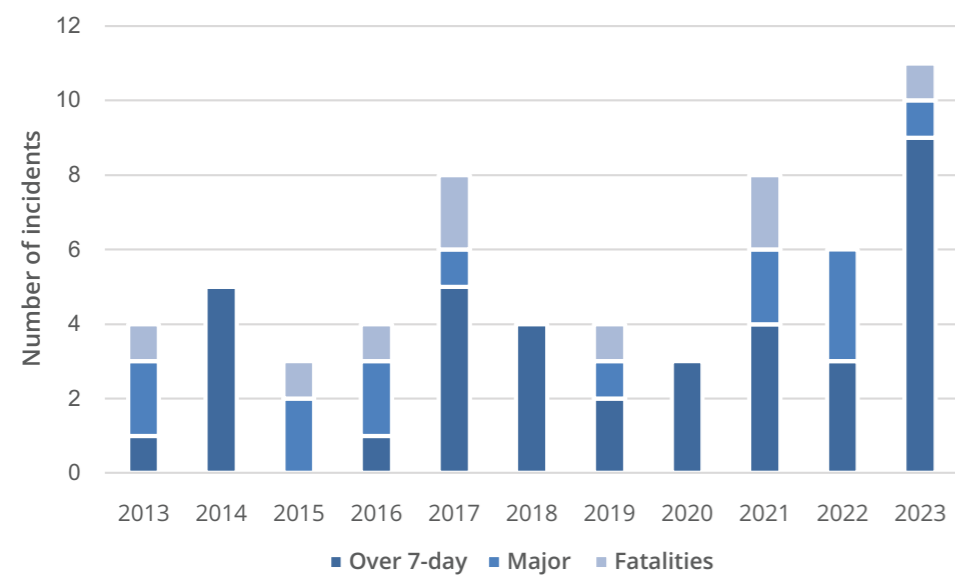


Image courtesy of Special Access © 2024

5. DISCUSSION AND RECOMMENDATIONS

The following recommendations are made to IRATA International although they apply equally to individual members as much as they do to the collective.

“... bad news is good news ...”

5.1 ACCIDENT AND INCIDENT REPORTING

Of the 267 accidents and incidents analysed, 124 reports (46.4%) were linked to 7 companies. These 7 companies account for just 4.78% of all hours worked. It seems likely that this is due to the lack of reporting by the majority as opposed to poor performance by the few. A learning environment – one in which

members strive to identify, learn and improve – is integral to a sound safety culture. Equally as important is recognising near misses and learning from them. For too long, the level of reporting has been poor. A robust reporting culture is considered essential.

Recommendation

No. 1 - Accident and incident reporting

The barriers to accident and incident reporting – and the importance of learning from near misses – should be reconsidered and action proposed.

The ‘Near Miss’ reporting categories should be reviewed to ascertain whether better information can be collected, and trends identified.

The reasons for the lack of ‘Near Miss’ reporting in training companies should be discussed.

Response from IRATA

IRATA has released a new incident reporting poster ‘REPORT A PROBLEM. PREVENT A FATALITY’ (<https://irata.org/downloads/23361>). This is part of an ongoing IRATA campaign to promote the importance of incident reporting.

5.2 COMMON THEMES

A review of the six previous WASA Reports (2018 to 2023) shows a number of common themes. In many instances, IRATA has published free advice already to assist members:

- The emphasis required by rope access safety supervisors and Level 3s, as well as those in training establishments, on preventing damaged and severed ropes.

Topic Sheet No. 5, Safe Rigging of Rope Access Equipment, <https://irata.org/downloads/2240>

Topic Sheet No. 6, The Protection of Ropes, <https://irata.org/downloads/2241>

- The prevalence of dropped objects that “...continue to haunt ...” (WASA 2018).

Topic Sheet No. 15, Tool Lanyards, <https://irata.org/downloads/2250>

Topic Sheet No. 3, Avoiding Dropped Back-up Devices, <https://irata.org/downloads/2238>

- Failure to identify, eliminate and/or controls hazards and the need to improve site hazard identification and risk assessment.

Topic Sheet No. 12, Hazard Identification/Risk Assessment, <https://irata.org/downloads/2247>

- The need to encourage members to report not only injuries but, as the reporting rate is very low, near misses.

Topic Sheet No. 27, Near Miss and Under Reporting, <https://irata.org/downloads/5853>

Topic Sheet No. 23, Accident and Incident Reporting, <https://irata.org/downloads/4414>

- The importance of equipment pre-use checks, teams being fully briefed, and the need for clear communication between all parties.

Topic Sheet No. 1, Inspection of Equipment, <https://irata.org/downloads/2236>

- Remaining alert to conditions, e.g. heat and physical effort, that may result in strains/sprains and ill-health (particularly during training).

Topic Sheet No 14, Environmental Conditions, <https://irata.org/downloads/2249>

Topic Sheet No. 16, Manual Handling and Strain Injuries, <https://irata.org/downloads/2251>

- The need for technicians to always behave responsibly and sensibly, follow written and oral instructions, and to raise concerns. (This might be summarised as ‘behavioural competence’.)

Topic Sheet No. 22, Belief-Based Safety, <https://irata.org/downloads/4413>

This year, the greatest number of immediate causes were:

- operator error or omission.
- falling or dropped object.
- contact with tool(s), material or equipment.

A qualitative assessment of the descriptions provided in the incident reports identifies several areas of note falling or dropped objects; ice; ill-health; musculo-skeletal; pipes; rope damage; wind turbines.

Focus should remain on these issues, some of which recur year on year.

Recommendation

No. 2 - Common themes

The recurring ‘common themes’ should be revisited and the need (where appropriate) for additional and/or updated guidance identified, prepared, and promulgated.

IRATA should review what is included within its ICOP, TACS and Membership Requirements (in respect of audit and reporting). Also, for training, what feedback (if any) is available as a result of its technician assessments, in particular at Level 3.

Input should be sought from RACs.

Members should review how they utilise available advice on training and briefing their employees.

Response from IRATA

This year IRATA has included the common themes documented through incident reporting in the assessor and instructor workshops. This enables IRATA to review possible changes to the TACS, increases awareness and aims to reduce the occurrence of ‘common themes’, e.g. dropped objects and rope damage.

5.3 PREVIOUS RECOMMENDATIONS AND OUTCOMES

The previous WASA Report (2023) included the following recommendations:

"...in view of the deleterious effect on statistics of the fatality rate prevailing, it is recommended that all seven fatalities in the last five years be collectively examined to determine if any underlying causes and 'lessons to be learnt' emerge that might not have been revealed by individual case reports..."

Response from IRATA

Lessons learnt from fatalities are published as safety bulletins, serious incident briefings and/or topic sheets when sufficient information is available. Due to the tragic circumstances and legal proceedings that surround fatalities, lessons learnt through the investigations are often not available until after legal proceedings are complete.

"...it is recommended that IRATA members critically examine their working practices and staffing, taking into account ... the findings in this report..."

Response from IRATA

IRATA provides information and guidance to its members based on the findings of the WASA Report and may include changes to IRATA's training, assessment and membership requirements where appropriate to do so.

IRATA Members use and share the information provided by the WASA Report and the core committees, to promote and establish safe practices in industrial rope access globally, not just amongst the IRATA Members but throughout the rope access community. Case studies are frequently raised and discussed at IRATA workshops.

"...Modifications and revisions to the accident/reporting format are required..."

Response from IRATA

In January 2024, based on the work of the Health and Safety Committee and IRATA Head Office, the 'IRATA Incident Report' [FM-021] form and the 'Guidance to IRATA Incident Reporting' [GU-265] document were updated extensively to be more user friendly and provide clearer guidance to members.

These updates have also clarified the requirements to Trainer Member Companies regarding what should be reported during IRATA training.

Recommendation

No. 3 - Register of recommendations

A 'Register of Recommendations' should be established – to which would be added any action(s) adopted – and a periodic progress report submitted to the Executive (board). It is suggested that this commences with the recommendations made in **WASA Report 2023**.

Members should be urged to consider the 'common themes' themselves (and any action(s) taken, as appropriate to their operations, could usefully be checked at internal audit).

5.4 'BEHAVIOURAL COMPETENCE' AND 'SAFETY CULTURE' ^{4 5}

An assessment of knowledge, skills and experience – traditionally defined as 'competence' – is fundamental to industrial rope access. Equally important, though, is **behavioural competence**. This helps to engender a sense of individual responsibility and accountability as part of an effective and strong safety culture.

The key aspects of a positive '**safety culture**' include:

- Management commitment which promotes high levels of concern throughout an organisation.
- Visible management which leads by example, demonstrates engagement, and acts.
- Good communication at all levels, where health and safety is a natural, unprompted consideration.
- Active participation and ownership of health and safety issues, with a common interest and narrative at all levels of the organisation, including visitors.

Important in demonstrating suitable '**behavioural competence**' are:

- Ethical principles, standards and conduct.
- Leadership, teamwork and communication.
- Individual and organisational competence.
- Personal responsibility and accountability.
- Duty of care to others.

Recommendation

No. 4 - Common themes

These two topics should be discussed with members and guidance prepared. Consideration should be given as to how good practice amongst members can be collated and shared. The role and scope of IRATA membership audits (and re-audits) should also be taken into consideration.

⁴ Source: BSI Flex 8670: v3.0 2021-04 Built environment – Core criteria for building safety in competence frameworks – Code of practice (BSI), <https://knowledge.bsigroup.com/products/built-environment-core-criteria-for-building-safety-in-competence-frameworks-code-of-practice?version=standard>

⁵ RR367 - A review of the safety culture and safety climate literature for the development of the safety culture inspection toolkit (HSE, 2005), <https://www.hse.gov.uk/research/rrhtm/rr367.htm>

5.5 LEADING AND LAGGING INDICATORS

Accident and incident statistics are, by their nature, 'lagging'. The period that elapses from the time of an event, and any report, to its eventual analysis and the publication of collective data is extended. The opportunity to promulgate lessons learnt promptly is lost. Lagging indicators can be said to be like driving a car looking only in the rear-view mirror.

Some organisations use 'leading' indicators. When used correctly these help organisations shape their future. Examples include manager safety observations, conversations on the shop floor, workplace inspections, training, identifying unsafe acts, sharing safety briefings, toolbox talks, etc. It is important to focus on key indicators and to review them periodically to see whether improvement has then resulted.

5.6 'HUMAN FAILURE' AND 'HUMAN FACTORS'

Incidents are often attributed to 'human failure' (see **Figure 23** on page 28). Useful guidance for those investigating accidents and incidents can be found in Reducing error and influencing behaviour, HSG48⁶. Investigations frequently fail to get to these underlying root causes.

5.7 DATA COLLECTED

Data collection should be the basis for driving improvement and for sharing and learning. It should not be an undue burden. It is useful to review periodically the data categories to determine whether improvement can be made. However, it's also recommended that changes not be made too frequently. This can make year-on-year comparisons more difficult, e.g. trends.

The definitions of a 'Dangerous Occurrence' (which is normally taken to be a reference to certain incidents

6 <https://www.hse.gov.uk/pubns/priced/hsg48.pdf>

7 Useful advice is available at <https://www.hse.gov.uk/humanfactors/introduction.htm>

Recommendation

No. 5 - Leading and lagging indicators

Dialogue should be commenced to identify the key 'leading' indicators in the context of rope access, and guidance prepared.

It is postulated that the indicators appropriate for operating members are not the same as those for training members.

Recommendation

No. 6 - 'Human failure' and 'Human factors'

It is recommended that these topics be discussed and advice, and perhaps training, prepared for members⁷.

It is suggested that this might form part of guidance and/or training on 'accident investigation'.

with a high potential to cause death or serious injury) and a 'near miss' (defined by IRATA as any event or situation where no personal harm or injury occurred but which could have led to injury or fatality) are similar. Is a distinction required to provide focus on smaller events? ('The little things matter'.) Or is a focus on 'high risk' events preferred?

Recommendation

No. 7 - Data collected

The data categories should be periodically reviewed to determine whether improvement can be made.

It is strongly recommended that ways in which year-on-year trends may be extracted be assessed.

It is recommended that benchmarking – against regional datasets – be investigated so that reliable comparisons can be made, e.g. UK and NSO RAC data against published HSE data⁸.

The data collected during the quarterly returns needs to be consistent with that collected after an accident or incident, e.g. grades.

The criteria for excluding accident and incident reports (if any) should be agreed and documented.

Review the definition of 'Dangerous Occurrence' as used by IRATA.

8 Injury Frequency rates, v1, 06/15 (HSE), <https://www.iso9001help.co.uk/free%20templates/HSE-injury-frequency-rates.pdf>

9 Issues in the measurement and reporting of work health and safety performance: A review, November 2013, Safe Work Australia, [issues-measurement-reporting-whs-performance.pdf](https://www.safeworkaustralia.gov.au/issues-measurement-reporting-whs-performance.pdf) (safeworkaustralia.gov.au)

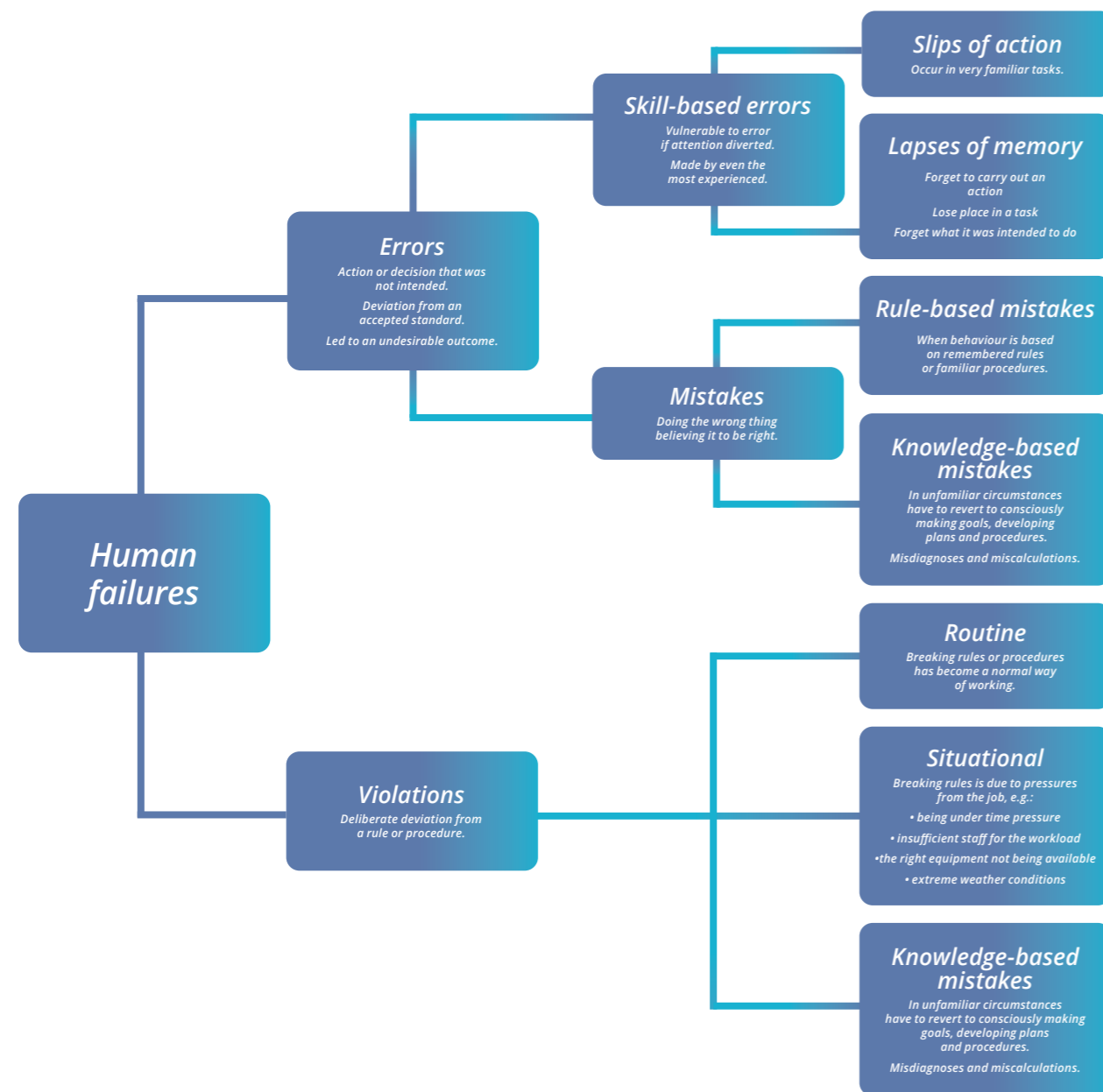


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“Plans are nothing;
planning is everything.”

Source: Dwight D. Eisenhower

Figure 23 : Causes of human failure



APPENDIX I GLOSSARY OF TERMS USED

NOTE: See 'Guidance to IRATA Work and Safety Statistics Return' [GU-022] v009, IRATA Incident Report [FM-021] form v003 and 'Guidance to IRATA Incident Reporting' [GU-265] v003

“It’s fine to celebrate success but it is more important to heed the lessons of failure.”

Source: Bill Gates

Throughout this report, reference is made to the following categories of work location:

‘On Rope’

Arranging, using and directly involved in rope access activity. It also includes access and egress activities to rope access work sites and setting up belays, rigging and de-rigging. Thus, this does not necessarily require a person to be ‘roped up’ or physically connected to active ropes. It may, for example, include setting up rescue equipment, work equipment (such as welding gear and inspection equipment) at the work site in readiness for immediate deployment on rope.

NOTE: Trainers, even if harnessed and prepared to go ‘On Rope’ should report work hours as ‘Other’.

‘Other’

Typically includes all other work, both on and off-site, in offices, etc. that is in support of rope access and related activities. For example, equipment inspection prior to removal to work site, logistics, storage, administration and standby duties (e.g. fire watching, surveillance and site security). ‘Other’ also includes all hours not accounted for by the above category including rope access trainers (unless actively on rope) and all non-rope access training. It **excludes** workers who are not involved in rope access activities.

‘Training’

All activities undertaken at rope access training facilities and establishments by trainees, including assessment. This **excludes** all trainers and training staff for rope access training who will be reported under either of the above categories as appropriate. All other unrelated training, induction courses, trial work, specialist courses (e.g. use of breathing apparatus, first aid) are **excluded** and should be reported under ‘Other’.

ACKNOWLEDGEMENTS

The assistance of the IRATA staff in compiling, arranging and presenting data is gratefully acknowledged. Also recognised is the considerable efforts of member

company staff who produce and submit the data required. This report could not have been prepared without their collective efforts.

APPENDIX I

GLOSSARY OF TERMS USED (continued)

For the purposes of this report, the distinction is made between:

‘Accident’

An unintended event when personal harm, injury or fatality occurs at work or is caused at work. This includes sprains, strains, illnesses or ill health issues brought on by or made worse by work.

‘Near Miss’, ‘Incident’ or ‘Dangerous Occurrence’

Any event or situation where no personal harm or injury occurred but which could have led to injury or fatality. Deliberate acts intended to cause harm or injuries are excluded, considered to be criminal act.

NOTE: The terms ‘Incident’, ‘Near miss’ and ‘Dangerous Occurrence’ are synonymous. Identification of the grade(s) of personnel involved is not required.

In dealing with accidents, the following terms are used unless noted otherwise:

‘Fatality’

A death within one year (of the incident) as a result of an accident or illness from work.

‘Major’ injury

Injuries that meet criteria common to most European agencies and other countries.

Typically, ‘Major’ injuries include, for example, broken major bones, any amputation, major dislocation, loss of eyesight and need for resuscitation.

NOTE: There is no ‘days lost’ element in a ‘Major’ injury. Thus, even if an injured person returns to work the next day, the nature of the injury might still make it a ‘Major’.

‘Serious incident’

IRATA-reportable incident resulting in a fatality or Major injury and arising from rope access work managed and/or undertaken by an IRATA Member Company

Source: Serious Incident Procedure, MP-255ENG

‘Over 7-day’ injury

In UK reporting, not a ‘Major’ injury but an injury requiring more than 7 days away from normal work irrespective of cause.

‘Less than 7-day’ injury

The criterion in the UK for a non-reportable accident is now less than 7-days off work (although required to be recorded by duty-holders). If any injury is incurred, no matter how trivial, the minimum reporting level is ‘Less than 7-day’ injury. In this report, this includes all incidents of ‘Ill-health’ and ‘Sprains/Strains’ unless resulting in an ‘Over 7-day’ injury.

A ‘Less than 7-day’ injury is synonymous with ‘Minor’ injury.

‘Ill-health’

A medical condition that leads to interruption or suspension of work due to non-injurious cause, e.g. psychological, heat or cold stress, taken unwell (headache, stomach upset), or other non-trauma medical condition brought on by or made worse by work. Reported as either a ‘Over 7-day’ or as ‘Less than 7-day’ injury or, if death occurs within 12 months, a ‘Fatality’.

‘Sprains/Strains’

Muscular injuries that result in prevention or cessation of work or training. As with ‘Ill-health’, reported as an ‘Over 7-day’ injury; otherwise as a ‘Less than 7-day’ injury. Pre-existing conditions made worse by work, including training, should be included.

‘Reportable Accidents’

For comparative purposes, this term is the total of all ‘Fatalities’, ‘Major’ injuries’ and ‘Over 7-day’ injuries.

APPENDIX II

REGIONAL DATA

IRATA currently has 16 Regional Advisory Committees (RACs), including “Other” (those not in any defined RAC).

Appendix II - Table 1 - Accidents and incidents reported by RAC in 2023

RAC	No. of incidents	Hours per reported incident	No. of members
Australasia	51	57,480	54
Benelux	7	85,453	31
Brazil	4	238,103	37
D-A-CH	0	-	4
East Europe	0	-	43
Far East Asia	1	156,750	19
Mediterranean	5	127,326	34
MECASA	8	1,176,885	83
North America	123	19,462	53
North Sea Operators	14	391,803	59
Others	0	-	5
Scandinavia	7	63,957	10
South East Asia	3	590,336	53
Southern Africa	3	330,111	32
Sub Sahara	0	-	27
United Kingdom	41	88,889	110
Total	267	122,830	654

APPENDIX II REGIONAL DATA (continued)

Appendix II - Table 2 - Summary of RAC employment by grade in 2023

RAC	Manager	Level 1	Level 2	Level 3	Other	Totals
Australasia	98	1,068	469	961	85	2,681
Benelux	52	274	109	267	92	794
Brazil	43	1,258	279	534	124	2,238
D-A-CH	6	7	4	16	8	41
East Europe	58	260	142	365	704	1,529
Far East Asia	20	42	38	105	2	207
Mediterranean	45	230	104	204	67	650
MECASA	172	2,442	1,353	1,169	667	5,803
North America	145	934	337	779	467	2,662
North Sea Operators	117	1,831	563	1,481	427	4,419
Others	3	50	8	16	4	81
Scandinavia	15	92	75	167	14	363
South East Asia	66	727	244	467	90	1,594
Southern Africa	64	337	179	291	88	959
Sub Sahara	36	134	137	144	106	557
United Kingdom	194	943	462	998	494	3,091
Totals	1,134	10,629	4,503	7,964	3,439	27,669

APPENDIX II REGIONAL DATA (continued)

Appendix II - Table 3 - Summary of RAC work hours by grade in 2023

RAC	Manager	Level 1	Level 2	Level 3	Other	Totals
Australasia	162,009	1,126,673	557,001	1,004,200	81,616	2,931,499
Benelux	52,913	186,876	80,172	209,328	68,882	598,171
Brazil	55,113	349,777	112,365	225,783	209,375	952,413
D-A-CH	4,922	5,388	2,645	15,586	9,768	38,309
East Europe	47,710	213,914	134,744	254,289	2,108,988	2,759,645
Far East Asia	17,473	40,877	34,960	61,650	1,790	156,750
Mediterranean	52,154	168,535	119,285	251,959	44,697	636,630
MECASA	460,400	3,655,671	2,196,422	1,785,843	1,316,742	9,415,078
North America	268,499	887,126	279,189	751,686	207,377	2,393,877
North Sea Operators	157,130	1,888,546	626,488	1,662,207	1,150,877	5,485,248
Others	2,296	7,473	2,938	4,994	2,173	19,874
Scandinavia	14,839	122,258	90,231	216,258	4,114	447,700
South East Asia	74,503	662,578	244,257	633,096	156,573	1,771,007
Southern Africa	43,112	368,765	202,741	312,167	63,549	990,334
Sub Sahara	56,057	106,444	92,348	141,785	158,102	554,736
United Kingdom	244,802	930,024	593,021	1,320,636	555,972	3,644,455
Total	1,713,932	10,720,925	5,368,807	8,851,467	6,140,595	32,795,726

APPENDIX II REGIONAL DATA (continued)

Appendix II - Table 4 - Summary of RAC work hours by location in 2023

RAC	Onshore - On Rope	Onshore - Other	Offshore - On Rope	Offshore - Other	Training	Totals
Australasia	1,511,577	790,069	326,713	245,127	58,013	2,931,499
Benelux	296,223	190,532	73,369	26,969	11,078	598,171
Brazil	217,691	254,817	206,715	51,802	221,388	952,413
D-A-CH	16,631	21,129	0	0	549	38,309
East Europe	129,631	1,589,283	159,700	824,098	56,933	2,759,645
Far East Asia	54,838	61,764	13,348	5,435	21,365	156,750
Mediterranean	187,837	173,172	65,128	95,254	115,239	636,630
MECASA	3,887,501	3,135,304	967,604	1,197,672	226,997	9,415,078
North America	1,511,646	677,091	63,244	56,511	85,385	2,393,877
North Sea Operators	724,024	755,056	1,739,395	2,238,603	28,170	5,485,248
Others	8,291	1,850	4,665	3,613	1,455	19,874
Scandinavia	51,917	89,584	94,785	195,977	15,437	447,700
South East Asia	428,704	310,023	394,732	560,445	77,103	1,771,007
Southern Africa	154,238	73,244	352,427	389,061	21,364	990,334
Sub Sahara	52,222	127,574	119,138	151,973	103,829	554,736
United Kingdom	1,385,920	1,310,414	468,841	217,390	261,890	3,644,455
Totals	10,618,891	9,560,906	5,049,804	6259930	1,306,195	32,795,726

APPENDIX II REGIONAL DATA (continued)

Appendix II - Table 5 - Training hours by RAC

RAC	2019	2020	2021	2022	2023
Australasia	40,095	46,133	30,627	42,054	58,013
Benelux	7,800	8,530	6,822	9,460	11,078
Brazil	119,711	103,169	145,496	214,658	221,388
D-A-CH	5,423	2,266	2,161	2,719	549
East Europe	58,536	40,065	48,100	54,867	56,933
Far East Asia	Previously included in other RACs			34,637	21,365
Mediterranean	19,984	25,598	30,193	36,671	115,239
MECASA	88,570	41,104	112,015	157,146	226,997
North America	78,107	48,156	62,730	75,636	85,385
North Sea Operators	10,456	9,437	7,626	65,682	28,170
Others	42,807	70,323	30,627	3,683	1,455
Scandinavia	4,315	3,976	3,316	4,448	15,437
South East Asia	94,404	77,706	49,726	81,315	77,103
Southern Africa	12,671	16,732	24,816	28,892	21,364
Sub Sahara	Previously included in other RACs			87,861	103,829
United Kingdom	152,537	75,927	97,058	162,820	261,890
Totals	735,416	569,122	651,313	1,062,549	1,306,195



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