Incident Summary II-674088-2018 (6507) (FINAL)

SUPPORTING INFORMATION	Incident Date		March 27, 2018
	Location		Whistler
	Regulated industry sector		Passenger Ropeway, Above-Surface Ropeway
	Impact – Injury	Qty injuries	1
		Injury description	Temporary shock and fear (visibly distressed)
		Injury rating	Minor
	Impact – Damage	Damage description	NA
		Damage rating	None
	Incident rating		Minor
	Incident overview		Shortly after loading onto the carrier seat with 3 other passengers, a 9 year old male skier came out of the seat and was hanging from the carrier. The ropeway was stopped when one of the passengers, on the carrier, alerted the attendant at the loading area. A group of attendants began to mobilize for a fireman's net rescue but the 9 year old fell before the attendants were able to fully assemble themselves. The 9 year old fell approximately 8 metres to the snow surface.
INVESTIGATION CONCLUSIONS	Site, system and components		Detachable quad chair
	Failure scenario(s)		The passenger failed to remain in the carrier seat after loading the carrier seat.
	Facts and evidence		Witness statement and lift operation's incident report indicate that: • The passenger (9 year old skier), with 3 other passengers, successfully loaded onto the carrier seat at the load point. • The carrier restraining device was not in the closed position. (the fall occurred close to the load point, passengers may not have had the time to have closed the restraining device). • The attendant stopped the ropeway when they heard a yell from one of the passengers on the carrier and noticed that the 9 year old was hanging from the carrier just past the station perimeter area (low clearance area). • A group of attendants began to mobilize for a fireman's net rescue but the passenger fell before they were able to fully assemble themselves for the rescue. Lift Operation Training Manual indicates that the attendant at the load area is to have a 180 degree view of the load area. That is, that the attendant is watching passenger loading in front of them, watching passengers approaching from the wait point of the maze and watching passenger in the carriers leaving the station.

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Causes and contributing factors	The passenger was very likely not securely seated in the carrier seat. Although witness statements indicate that the restraint bar was open when the passenger fell, it may not have been possible for the passengers to have lowered the restraint within the time they loaded to when the passenger slipped out of the carrier seat. The procedure for the attendant at the load area is to maintain a 180 degree view of the load area. As this occurred a short distance from outside of the station it is possible that this procedure was not being fully practiced.

Photos or diagrams (if necessary)