TECHNICAL SAFETY BC

Incident Summary #II-910416-2019 (#15308) (FINAL)

SUPPORTING INFORMATION	Incident Date		September 22, 2019
	Location		Whistler
	Regulated industry sector		Passenger ropeways - Above surface ropeway
	Impact – Injury	Qty injuries	1
		Injury description	Described as a 1-2” laceration to the posterior of head, requiring stiches.
		Injury rating	Moderate
	Impact – Damage	Damage description	Not applicable
		Damage rating	None
	Incident rating		Moderate
	Incident overview		An attendant that was disposing of a deceased mouse in a low clearance area (LCA) in front of a ropeway station, was struck in the head by a moving carrier (gondola cabin).
INVESTIGATION CONCLUSIONS	Site, system and components		• A detachable grip, high speed gondola (maximum rope speed of 6 m/sec). • The ropeway utilizes 10 passenger gondola carriers. • Typically a cordoned off region is situated in front of the top and bottom stations to prevent access to a low clearance area (LCA). The LCA is where the bottom of the carrier has a vertical clearance to the ground of less than 4m. • Operator’s policies require that: - Staff entering the LCA will set the ropeway speed to slow (1.5 m/sec). A second staff member will be positioned in the vicinity of a stop button with a view of the staff member entering the LCA. Staff working in the LCA area with the ropeway operating are required to be wearing a helmet. - The ropeway will be stopped if the staff member enters the LCA alone.

Failure scenario(s)	Staff member(s) failed to take necessary measures in ensuring the collision risk with moving carriers was controlled.
Facts and evidence	• The narrative of events is based on reports provided by the operating contractor, that is: - At the top station, a ropeway attendant was disposing of a dead mouse in the LCA area a short distance from the front of the ropeway station on the outgoing side (side in which carriers are leaving the station heading down). - While the attendant was in the LCA, they were struck in the back of the head by a moving carrier. Report indicates that the ropeway was operating a speed of 4 m/sec. • Training manual submitted by the operating contractor for review provides documented policy regarding the methods for staff to enter the LCA. These procedures include: - Staff entering the LCA will set the ropeway speed to slow (1.5 m/sec). A second staff member will be positioned in the vicinity of a stop button with a view of the staff member entering the LCA. - The ropeway will be stopped if the staff member enters the LCA alone. - Staff entering the LCA area with the ropeway operating are to be wearing a helmet (type of helmet is specified in the training manual). Note: report indicates that the attendant was not working alone at the time the incident occurred and there is no evidence that the attendant that entered the LCA was wearing a helmet.
Causes and contributing factors	It is very likely that the attendant was not following operating procedures related to persons accessing the LCA. That is: • The ropeway was not slowed prior to the attendant entering the LCA. • A second attendant was not situated at a stop button with the attendant in the LCA in view. • The attendant was likely not wearing a helmet when they entered the LCA.