CASE 1
Instructor Died whilst Preparing Zip Wire Session

Lessons Learned Group

Narrative

At an outdoor zip wire facility owned by a third party, an instructor arrived early and alone to set up the equipment prior to the arrival of her client. She was wearing a helmet and using her own sit harness together with a chest harness issued with the centre equipment.

She had written a risk assessment for the zip wire activity and had undertaken induction training for the activity some 6 months previously, but it is unclear whether she had led any subsequent sessions. On later inspection, the zip wire and its associated equipment were found to be in good working order.

On arrival at the site, the client found the instructor stationary and suspended about 2m above the ground at the dismount point of the zip wire.

It is unclear whether the instructor had intentionally zipped the wire, or whether she had slipped from the platform whilst rigging it.

Her sit harness was found on the ground beneath her. It appears that, whilst attempting to escape from the chest harness from which she was suspended, her helmet somehow obstructed her escape. Death occurred primarily through asphyxiation caused by pressure from her helmet strap.

The coroner recorded a verdict of death by misadventure, and accepted that the instructor had made errors on the day which had led to her death in unusual and tragic circumstances.

The Lessons

1. An instructor may overlook important safety information, or key operational procedures if the time between induction and leading the activity is too great.

2. If a chest and sit harness combination is used for a zip wire (or any other activity), then they must always be linked in a way which prevents the wearer's weight being transferred wholly to the chest harness.

3. Instructors should be aware of the increased risks of travelling a zip wire or similar installation whilst alone.

4. The benefits of setting up and checking equipment before the arrival of clients should be balanced against the increased risks that can arise from lone working.

The Lessons Learned Group (LLG) is a small group of professionals and enthusiasts in adventure activities, brought together by a common aim to incorporate any lessons that can be learned from accidents into ongoing good practice.

Our intention is to present an objective summary of an incident together with possible lessons. We do not aim to allocate blame or responsibility and our report represents the views of the individual members of LLG and not of any official body.

Information not currently available to us may render our comments inaccurate and the lessons identified may or may not have influenced the actual outcome. Any report published has been agreed by at least four individuals within the Group as meeting these aims.