

Lessons Learned from Management Failings at a Climbing Wall

by the Lessons Learned Group

Narrative

An eight year old primary school pupil was involved in a fall from an indoor climbing wall whilst attending a non-licensable residential activity centre. He fell from approximately six metres to the floor and, fortunately, only sustained a fractured lower leg and bruising, although he spent a long time in plaster.

It was not possible to ascertain the exact cause of the accident but it is most likely that this was a direct result of some form of human error on the part of the instructor who was belaying. The karabiner was left attached to the rope at the top of the wall, but it is unclear if it was screwed up or not. What was clear is that the centre had not followed their own written operating procedures for the training, assessment, monitoring and deployment of the instructor concerned. These procedures should not only ensure technical competence, but also be so designed as to minimise the chances of human error. All instructors, and newly qualified ones in particular, make mistakes at some time or another, but each mistake need not result in an accident.

Subsequent investigation revealed that the equipment used was in good condition and the belay system used was entirely appropriate.

However, on the day of the accident the centre was not operating in accordance with its own written operating systems. These procedures required two instructors as a minimum to run the session, but there was only one. The instructor had not been fully signed off as competent, as required by the procedures. These same procedures stipulate a high level of instructor monitoring, but this instructor had not been observed nor signed off for operational deployment since his training and the assessment of his technical competence a month earlier.

Moreover, a chest harness was required by the procedures for this age of client, but one was not used, and according to the centre's risk assessment, gear loops should be removed from sit harnesses, but the harnesses used still had gear loops fitted. Although neither of these technical discrepancies



contributed in any way to the accident, they did indicate a further gap between written procedures and actual practice.

Written operating procedures will not in themselves increase the safety of a session if the staff managing, monitoring, and delivering activities are experienced and competent and, therefore, able to exercise professional judgement. Where, however, managers and instructors have minimal activity experience and competence then the written guidance assumes a far greater level of importance.

The centre's procedures state that in-house training needs to be delivered by someone approved by their external technical adviser, who themselves needs to be experienced in the operation of climbing walls and hold at least the Mountaineering Instructor Award (MIA). This was done. The assessment of technical competence (e.g. whether the candidate can put harnesses on correctly, attach students to the rope correctly, and belay correctly, etc.) was to be carried out by an experienced MIA, and this was also done. However, their procedures also require the instructor to be finally signed off for operational deployment by a senior member of the centre's staff, but this was not done.

The instructor had undertaken three training sessions followed by an assessment – all within a seven day period. The centre requirement states that there must be at least eight hours of training. There is no indication of whether the instructor had any previous experience of climbing prior to commencing training.

The instructor's in-house instructional records indicated an overall result of 'Pass' for climbing by an MIA. However it also carried a caveat from the assessor stating: "Be a bit more enthusiastic. Watch two sessions and assist two sessions to gain an insight". It is unclear whether these four sessions of observation and assisting were recommended purely to gain an insight into being enthusiastic or to gain greater experience before running sessions. In either event this comment from the assessor does not appear to have been acted upon, and he was never finally signed off by the centre.

Thus whilst the exact cause of the accident remains uncertain it was known that the centre had not followed their own minimum requirements for ensuring the competence of the instructor who, even if adequately competent, should not have been instructing, and should certainly not have been instructing on his own.

Not surprisingly the centre was prosecuted for breaches of Health and Safety at Work etc!

Lessons Learned

1. Activity providers should write in their supporting documents what they actually do, not what they think they do, nor what they aspire to do, nor what they would prefer others to believe they do.
2. Minimum standards should be viewed as the minimum acceptable. By definition anything less than that is not acceptable.
3. It is not in anyone's interest to deploy instructors who do not have the necessary competence to carry out the tasks asked of them. Managers who do not ensure the competence of those which they deploy are simply inviting problems.
4. Even the most robust written protocol is prone to human error. There are many ways to mitigate against this, however all of them require clear recognition by management that human error is a more significant cause of accidents than equipment failure, inappropriate procedures or even environmental impact.

In this case two levels of human error occurred:

- a. whatever the instructor did or didn't do that resulted in the accident
- b. the omissions of managers for not ensuring that company procedures/policies were adhered to.

Training for both managers and instructors needs to pay significant attention to the role of human factors in accident causation.

5. Monitoring, at all levels of an operation, is an essential tool in the battle against human factor related incidents. It helps to ensure that actual and documented procedures are in step and it also helps to keep instructional staff fresh and alert. ■

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The Lessons Learned Group 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.

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