NSW GOVERNMENT | Industry & Investment

SAFETY ALERT

Field technician trapped between vehicle bull bar and stock gate

INCIDENT

A four wheel drive service vehicle rolled forward from a parked position and pinned the driver, a field technician, between the vehicle's bull bar and a stock gate. The field technician did not suffer serious injuries but the outcome of this incident could have been fatal.

CIRCUMSTANCES

The incident occurred at approximately 3:00pm in clear, dry, still weather on an isolated dirt track at a stock gate accessing an exploration site.

The field technician was driving between sites on the exploration lease when he stopped in front of the stock gate and got out to open the gate. As he walked between the vehicle and the gate the vehicle rolled forward and pinned him between the vehicle's bull bar and the stock gate.

The field technician was alone at the time of the incident. He was discovered approximately forty five minutes later in a distressed state, semi-conscious, vomiting, and experiencing difficulty breathing and speaking. He was taken to hospital by ambulance for treatment and released forty eight hours later. Fortunately he had no internal damage or fractures but he did suffer significant bruising.

INVESTIGATION

The investigation found that the field technician involved in the incident had extensive experience driving four wheel drive vehicles. He had also completed a generic site induction and received basic instruction in the safe operation of four wheel drive vehicles. However, he had only commenced employment four and a half days before the incident.

The four wheel drive service vehicle was purchased second-hand but appeared to be in good working condition. It was reported that the service vehicle had been inspected by a competent mechanic before its purchase.

Inspectors were unable to find the pre-start inspection book, emergency response procedure, service vehicle safe work procedure or fire extinguisher in the service vehicle.

The investigation found that a pre-start inspection of the service vehicle had not been conducted on the day of the incident.

The park brake was examined and tested during the investigation and was found to be functioning correctly.

The gradient of the track at the stock gate appeared level. However, field trials were conducted by parking the service vehicle in various locations adjacent to the stock gate including its reported location at the time of the incident. When the vehicle's engine was idling, the transmission in neutral and the park brake *not* applied; there were some locations where the vehicle rolled forward towards the stock gate.

Similar serious incidents with vehicles rolling and pinning a person at a gate have occurred at other sites within Australia when park brakes were not applied or were inadequately applied.

RECOMMENDATIONS

1. Mine and exploration operators should ensure that pre-start inspection books are issued and used for all vehicles to document mechanical defects or concerns relating to a vehicle's operation. Pre-start inspections should be conducted by competent persons to check basic operational requirements as well as safety critical systems prior to the vehicle's use.

2. Mine and exploration operators should establish or review safe work procedures for the operation of all vehicles to ensure uncontrolled movement of these vehicles does not occur, especially when parking.

3. Mine and exploration operators should consider installing alarms that sound a warning if the park brake is not applied before an operator leaves the vehicle. Alternatively, mine and exploration operators should consider the feasibility of installing an interlock system on vehicles to ensure the park brake is applied before an operator leaves the vehicle.

4. Mines and exploration operators should review their Mine Safety Management Plan to ensure it adequately addresses induction and training for new employees, pre-start inspection procedures, emergency response procedures, vehicle maintenance procedures and all vehicle operations in remote areas.

NOTE: Please ensure all relevant people in your organisation receive a copy of this Safety Alert, and are informed of its content and recommendations. This Safety Alert should be processed in a systematic manner through the mine's information and communication process. It should also be placed on the mine's notice board.

Signed

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MINE SAFETY OPERATIONS BRANCH
INDUSTRY & INVESTMENT NSW

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