

# Monthly periodical

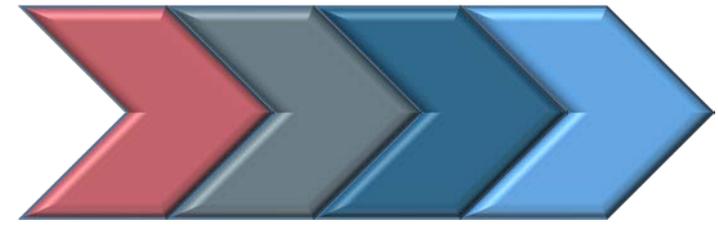
Queensland Mineral Mines & Quarries Inspectorate  
February 2021

Mineral Mines & Quarries Inspectorate



**Resources Safety & Health**  
Queensland

# Serious Accidents

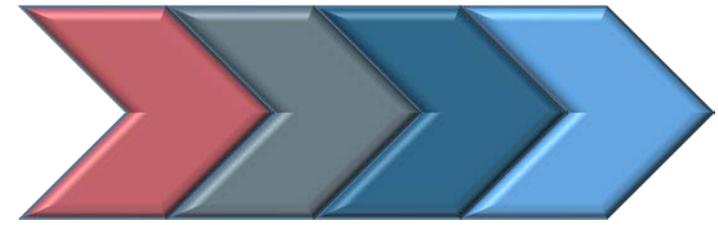


There was one serious accident:

On 3 February 2021, a worker was making adjustments to the compressed air delivery system on a drill rig when it was engulfed in fire causing serious burns to the worker's face, arm, chest and back. Fortunately the worker's eyes were protected from the fire by safety glasses.

Further information is available at <https://www.rshq.qld.gov.au/safety-notices/mines/fire-on-rc-drill-rig-from-compressed-air-system>

# High Potential Incidents



There were 18 high potential incidents reported. The most common contributors were human error, falling flying material or objects and electrical equipment.

# Uncontrolled release of compressed air.

On 7 February 2021, an electrician was dragging a pressurised 110 mm polyurethane pipe from inside a bunded area across the face of the high wall. They were able to do so from outside the bunded area by lassoing the pipe using a hemp rope.

During this activity the handle on the ball valve at the top of the pipe was knocked open allowing the air to discharge from a 100 m length of pipe all the way back to the compressor on top of the high wall. The pipe flayed around breaking off the discharge valve.

There were no injuries.



# Uncontrolled release of compressed air.

## Causes

There was no single person accountable for the installation of services at this portal and as a consequence this put pressure on the completion date.

Geotechnical reports were not taken into account when the service lines were installed.

As so often happens the workers decided to get on with an unfamiliar job with the best of intentions only to get into trouble. They did not know they were moving a pressurised line and that the pressure could not be reliably contained.

After the service line had been pressurised, the pressure could only be released by opening the valve at the end of the pipe.

The service lines were not restrained.

# Uncontrolled release of compressed air.

## Recommendations for inclusion in mining and quarrying safety and health management systems

- Allocate accountability for projects so that timeframes are met without putting pressure on front line workers. (Administration)
- Plan installation of services so that critical components such as isolation and bleed valves can be accessed. (Engineering)
- Recognise situations where the containment of pressure cannot be guaranteed.
- Restrain the air lines to prevent them whipping about when air is being discharged. (Engineering)
- Broadcast internal safety alerts as the mine has done in this case. (Administration)

For further information go [https://www.rshq.qld.gov.au/data/assets/pdf\\_file/0009/1438398/qld-guidance-note-qgn02-solation-of-plant.pdf](https://www.rshq.qld.gov.au/data/assets/pdf_file/0009/1438398/qld-guidance-note-qgn02-solation-of-plant.pdf)

# Rear dump truck backs into front end loader.

On 17 February 2021, a dump truck was backing up to tip its load at the overburden dump when it collided with the loader that was pushing off.

There was significant damage to the handrails on the loader and the truck had to be moved in order to get the operator out of the cab.

There were no injuries.



# Rear dump truck backs into front end loader.

## Causes

At the start of dayshift there was positive communication by the truck operator and acknowledgement by the loader operator.

The repetitive nature of the task led to complacency later in the day when there was no communication between the truck and the loader operator.

There was a lack of attention to their surroundings by the truck operator

# Rear dump truck backs into front end loader.

## Recommendations for inclusion in mining and quarrying safety and health management systems.

- Only one worker should control the work area, in this circumstance the loader operator. (Administration)
- Where practicable the tipping and pushing off activities should be separated for instance by:
  - Organising the work so that the trucks are not dumping when the loader is pushing off. (Separation)
  - Having a dividing bund down the centre of the dump when there is sufficient space. (Separation)
- Install a portable call point notice where trucks have to call up from. (Administration)
- Everyone on site, particularly supervisors, should be listening to make sure that the practice of positive communication is being followed. (Administration)
- The use of the communication system should be confined to operational matters. (Administration)

Note: There have been five vehicle to vehicle incidents in the last six months.

# Telehandler strikes wall of decline and loses its load.

On 23 February 2021, a telehandler was transporting a 1.6 tonne reel of cable down a decline when it was steered into the wall due to a perceived loss of braking. On impact, the load was dislodged and travelled several metres into the back of an agitator truck also going down the decline. There were no injuries.



# Telehandler strikes wall of decline and loses its load.

## Causes

The telehandler has a toggle switch that can be set to either have the transmission engaged or disengaged when the service brake is applied. When disengaged, this function is used to improve the performance of the implements.

The telehandler was travelling at a speed that required repeated use of the service brake. The toggle switch was set to be disengaged. Therefore there was a loss of engine braking requiring the service brake to do more work.

The operator was aware that the transmission was disengaging when they applied the service brake as they travelled down the decline but continued on. The operator did not fully understand why the transmission was disengaging when the service brake was applied. The operator was unaware that the switch was set to disengage.

The training and assessment package was specific to the telehandler but did not include the functions that enabled the transmission to be disengaged when the service brake was applied.

# Telehandler strikes wall of decline and loses its load.

## Causes

Irrespective of the lack of retarding effect that was lost due to the transmission being disengaged on application of the service brake, the service brake should still control the telehandler.

The Original Equipment Manufacturer (OEM) states that in avoiding a crush hazard, applying the park brake while travelling will cause unit to stop abruptly and could cause load loss. It also states that to stop the machine in an emergency, apply the park brake. After the incident the park brake failed the static test set out by the OEM in the Service Manual and at prestart.

The service brake passed the static brake test but the mine is still carrying out a thorough investigation to determine if the brakes were as effective as they should have been.

# Telehandler strikes wall of decline and loses its load.

## Recommendations for inclusion in mining and quarrying safety and health management systems.

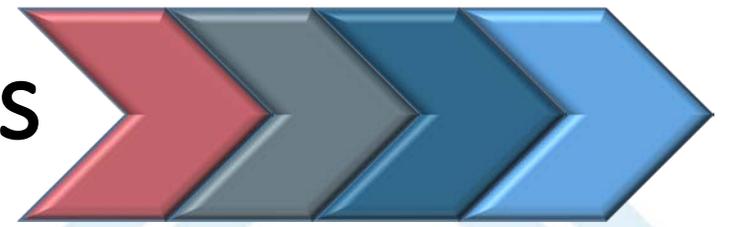
- The outcome of training and assessment must be for workers to know how to safely operate the specific make and model of plant which includes an understanding of all safety critical functions. (Administration)
- Operators must bring plant safely to a stop if they have a concern with braking systems. (Engineering)
- The performance of all braking systems must be understood, maintained and monitored so that it is known they are capable of keeping telehandlers under control under all circumstances. (Engineering)
- Consider whether there is an alternative way of transporting loads down the decline. (Elimination)

Use Australian Standard 2550.19 for telescopic handlers as a source of information to carry out a risk assessment that covers all routine work or one that is job specific.

The risk assessment should at least include:

- how loads are to be secured to the implements (Engineering)
- which way the load should be facing while tramming downhill. (Engineering)

# Contact us



## Mineral Mines and Quarries Inspectorate

General enquiries:

- [Contact your regional inspectorate staff](#)

Report emergencies, incidents or illness:

- Townsville: (07) 4447 9282
- Mt Isa: (07) 4745 4117
- Brisbane: (07) 3330 4273

For previous periodicals go to <https://www.business.qld.gov.au/industries/mining-energy-water/resources/safety-health/mining/accidents-incidents-reports/serious-accidents>