

MNM Fatal 2013-13

- Powered Haulage Accident
- September 19, 2013 (Pennsylvania)
- Dimension Slate Mine
- Laborer
- 31 years old
- 14 years of experience

Overview

The victim was killed when the flatbed cargo truck he was operating overturned. He was transporting four full 250-gallon water totes, which were not secured, while traveling uphill on a steep mine access road. One of the totes shifted and fell off the bed of the truck onto the roadway. The truck began drifting backwards on the 25 percent grade and the remaining water totes shifted. The service brake failed and the victim could not control the truck. The truck turned sharply to an embankment and rolled over onto its roof. The victim was ejected from his seat and entrapped in the operator's cab.

The accident occurred due to management's failure to establish policies and procedures to ensure the victim could maintain control of the truck he was operating. The shifting water totes compromised the stability of the truck, the rear left wheel (driver's side) of a dual tire system (outer tire) was missing on the truck compromising the stability of the truck, the service braking system for the truck had not been maintained in a functional condition, and the main brake line on the truck rusted through, resulting in the brake fluid leaking out of the brake system. Consequently, the victim could not maintain control of the truck. Additionally, the driver was not wearing the provided seat belt; this contributed to the severity of his injuries.





Root Causes

Root Cause: Management failed to ensure that routine maintenance was performed on the braking system on the truck. The service braking system for the truck had not been maintained in a functional condition. The main brake line on the truck rusted through, resulting in the brake fluid leaking out of the braking system.

Corrective Action: Management established policies and procedures to ensure that maintenance is performed on haul trucks to keep the equipment in functional condition.

Root Cause: Management failed to develop policies and procedures to ensure that loads are properly secured before being transported on trucks.

Corrective Action: Management developed procedures to be followed to properly secure loads before materials, including totes, are transported on trucks. Mobile equipment will also be kept in functional condition. All persons have been trained regarding these procedures.

Root Cause: Management policies, procedures, and controls did not ensure the victim wore his seat belt when operating the haul truck.

Corrective Action: All truck drivers received additional training regarding the required use of seat belts when operating haul trucks. Management will monitor truck drivers to ensure seat belts are worn.

Best Practices

- Task train mobile equipment operators adequately and ensure they demonstrate proficiency in all phases of mobile equipment operation before performing work.
- Conduct adequate pre-operational checks prior to operating mobile equipment.
- Ensure that loads are stable and secured before transporting.
- Never exceed equipment manufacturer's load limits.
- Always wear a seat belt when operating self-propelled mobile equipment.
- Maintain control of self-propelled mobile equipment while it is in motion.
- Operate mobile equipment at speeds consistent with the conditions of roadways, tracks, grades, clearance, visibility, curves, and traffic.