



The National Institute for Occupational Safety and Health (NIOSH)

Promoting productive workplaces  
through safety and health research **NIOSH**

# Order Selector Dies After Jumping 16 Feet From an Elevated Pallet on an Overturning Forklift in South Carolina

FACE 9124

## SUMMARY

A 22-year-old order selector (victim) died after jumping 16 feet from an elevated pallet on a forklift when the forklift began to overturn. The victim had been selecting items from the third tier of shelving to fill orders that were to be shipped that day. The victim wore a safety belt and lanyard connected to an anchor point on the mast of the forklift. The victim had finished selecting all the items available in the aisle in which he was positioned. He instructed the forklift operator to move the forklift into the next aisle. Without lowering the pallet, the operator backed the forklift out of the aisle. As the forklift was turning into the next aisle, it began to overturn. The victim unhooked his lanyard from the anchor point and jumped from the pallet. He fell 16 feet, striking his head on the concrete floor. He died 6 hours later. NIOSH investigators concluded that, in order to prevent similar occurrences, employers should:

- **ensure that workers continually adhere to the safe work procedures that have been established by the employer**
- **encourage all employees to actively participate in workplace safety**
- **routinely conduct scheduled and unscheduled worksite safety inspections.**

## INTRODUCTION

On July 24, 1991, a 22-year-old order selector died from injuries sustained the previous day when he jumped 16 feet from an elevated pallet on an overturning forklift. On July 29, 1991, officials of the South Carolina Occupational Safety and Health Administration notified DSR of this fatality, and requested technical assistance. On August 21, 1991, a DSR safety specialist traveled to the incident site to conduct an investigation. The incident was reviewed with company representatives, the county coroner and sheriff, and the OSHA compliance officer. Photographs of the incident site taken immediately following the incident were reviewed during the investigation.

The employer was a distributor for the food service industry, providing foodstuffs and other related items such as towels, tablecloths, and silverware. The employer had been in operation for 60 years and employed 175 workers, including 15 order selectors. The employer had a corporate safety director. The operations manager at the facility managed the safety function as a collateral duty. The company had a comprehensive safety program, written safety policy, and written safe

work procedures. The company required a pre-employment physical and drug screening. The warehouse supervisor reviewed the safe work procedures with new employees. Employees also received instruction in safe lifting procedures, both verbally and by watching films on safe lifting procedures.

The employer's training program required new employees to work 12-hour shifts their first few days at work. For the first 4 hours of the shift, new employees were accompanied by a senior worker who taught them the layout of the warehouse and the locations of the various products. Forklift operators received additional training, and were required to pass a written examination and demonstrate proficiency at operating a forklift before being allowed to operate in the warehouse. This was the first fatality at the facility and the employer had not experienced a lost time injury for 3 years preceding this incident.

## INVESTIGATION

The victim was one of 15 order selectors that selected items from warehouse shelving to fill orders for shipment. The victim and a co-worker (forklift operator) were working the night shift. After receiving orders from the night shift operator, they traveled to the area of the warehouse that contained the items necessary to fill the orders. The victim would stand and stack the order from a pallet placed over the forks of the forklift. The victim and co-worker entered the first row of shelving to pull items. The victim, who was wearing a safety belt and lanyard, stepped onto the pallet and hooked his lanyard to an anchor point on the mast of the forklift. When the victim was secured, the co-worker raised him to the third level of shelving, 16 feet above floor level. When the victim had selected all the required items in that row, he instructed the co-worker to back the forklift out of that row and into the adjacent row. The victim, who had seniority, told the co-worker to leave the forks elevated to save time.

As the forklift was turning into the next aisle, the forklift began to overturn toward the wall of the warehouse. The victim unhooked his lanyard and jumped from the pallet toward the warehouse wall. Although unwitnessed, it is believed that the victim's feet struck an 18-inch steel I-beam running along the inside wall of the warehouse (14 feet above floor level) causing him to turn over and strike his head on the concrete floor. The forks, pallet, and items came to rest against the warehouse wall.

The co-worker went to the victim and found him unconscious, but breathing. He then ran to the warehouse supervisor to inform him of the incident. The supervisor telephoned the emergency medical service (EMS) from the warehouse office. Two squads of EMS personnel (eight persons) arrived within 4 minutes and stabilized the victim. The victim was transported to the local hospital then life-flighted to a trauma center where he was pronounced dead 6 hours after the incident.

## CAUSE OF DEATH

The attending physician listed the cause of death as closed head trauma.

## RECOMMENDATIONS/DISCUSSION

Recommendation #1: Employers should ensure that workers continually adhere to established safe work procedures.

Discussion: Employers should continually stress the importance of adherence to established safe work procedures. In this instance, forklift operators were trained not to move a forklift unless the load was at the lowest point that would allow travel by the forklift. The workers in this incident did not satisfy this requirement. Since the incident, the company had a representative of the forklift manufacturer present a 7-hour seminar on forklift safety. The representative then tested the operators' operating abilities. All operators passed the test.

Recommendation #2: Employers should encourage workers to actively participate in workplace safety.

Discussion: Employers should encourage all workers to actively participate in workplace safety and should ensure that all workers understand the role they play in the prevention of occupational injury. In this instance, the victim, a senior employee, told the operator to move the forklift with the load in the air, in violation of established safety rules. Employers must instruct workers of their responsibility to participate in making the workplace safer. Increased worker participation will aid in the prevention of occupational injury.

Recommendation #3: Employers should routinely conduct scheduled and unscheduled worksite safety inspections.

Discussion: Scheduled and unscheduled safety inspections should be conducted by a qualified safety professional. No matter how comprehensive, a safety program can not be effective unless implemented in the workplace. Even though these inspections do not guarantee the elimination of occupational injury, they do demonstrate the employer's commitment to the enforcement of the safety program.

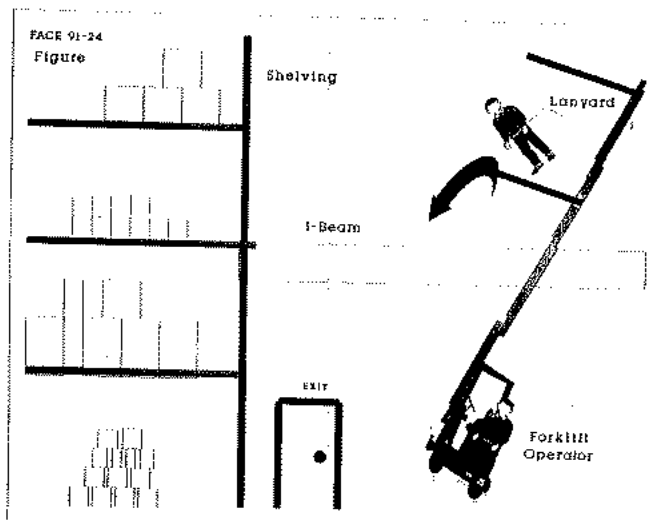


Figure.

[Return to In-house FACE reports](#)

Last Reviewed: November 18, 2015

Was this page helpful?