

June 6, 1996

Nebraska FACE Investigation 96NE006

SUBJECT:

Worker Crushed in Forklift Overturn

SUMMARY:

A 25-year-old night stocker at a retail lumber yard was killed when a forklift he was driving overturned and he was thrown or jumped out of the seat and was crushed by the rollover protective structure of the forklift. The victim was not wearing a seat belt at the time of the incident.

The Nebraska Department of Labor investigator concluded that to prevent future similar occurrences:

- * Personnel should comply with all requirements of their company's Injury Prevention Program, specifically the requirement to wear seat belts while operating forklifts.
- * Employers should retrofit all forklifts in the company with seat belts.
- * Employers and employees must ensure unauthorized personnel do not ride on forklifts.
- * Employers should consider implementing a spot inspection program to ensure all employees are complying with safety requirements and develop and enforce consequences for noncompliance.

PROGRAM OBJECTIVE:

The goal of the Fatality Assessment and Control Evaluation (FACE) workplace investigation is to prevent work-related deaths or injuries in the future by a study of the working environment,

the worker, the task the worker was performing, the tools the worker was using, and the role of management in controlling how these factors interact.

This report is generated and distributed **solely** for the purpose of providing current, relevant education to employers and the community on methods to prevent occupational fatalities and injuries.

INTRODUCTION:

On April 15, 1996, at approximately 11:30 p.m., a 25-year-old night stocker at a retail lumber yard sustained fatal injuries when a forklift overturned on him. The Nebraska Department of Labor became aware of this incident from the news media. The Nebraska FACE investigator accompanied OSHA investigators to the incident site on April 16 and 17, 1996. Interviews were conducted with both the employer and employees.

The employer is a retail lumber yard which has been in business for 28 years and employs more than 17,000 personnel. The store which experienced the fatality has been in business for 11 years and employs 77 personnel. This was the first fatality in the history of this store.

The company has a written safety program and an active safety committee. The company has a full-time safety manager at the regional level. At the incident store, management personnel are responsible for implementing safety policy in addition to their other responsibilities. The victim had worked for the company for six and a half years of which the last four and a half years were at the incident store.

The victim and a coworker involved in the incident had both been trained in forklift operation. This training consisted of a video, a workbook and a written test, as well as hands-on training with a qualified individual. This training was documented in their personnel files.

INVESTIGATION:

The victim, a night stocker at a retail lumber yard, had begun the night shift at 8:30 p.m. He had been unloading a truck with the forklift prior to the incident. The regular night supervisor had

begun his vacation the day of the incident and the victim was the acting supervisor in his absence. After the victim finished unloading the truck he filled out some paperwork and then drove the forklift, with a coworker riding on the forks, away from the truck. They noticed another truck had arrived to be unloaded and they drove to it and informed the truck driver they would not be able to unload it until 4:30 a.m. They then drove west through the lumber yard and as they approached a corner the right mast of the forklift struck a concrete reinforced steel pole. There were two poles like this, approximately 3 ½ feet high and painted yellow, which were protecting a fire hydrant. After striking the pole, the right front tire of the forklift rode up the pole, bending it approximately 45 degrees from upright. This caused the forklift to overturn to its left. The coworker, who was riding on the forks facing the driver (victim) jumped clear. The victim was either thrown or jumped to his left. The top of the roll bar on the forklift landed in the middle of his back, pinning him to the asphalt. Another coworker nearby heard the accident and responded. The coworker who was riding on the forks called 911 and the other coworker went and got a second forklift and raised the incident forklift off of the victim approximately two and a half feet. The paramedics arrived in about five minutes. The victim was taken to a local hospital where he was pronounced dead at 1:10 a.m. from multiple internal injuries.

An inspection of the forklift involved in the incident showed basic safety features to be operating normally to include, steering, brakes, and lights. It was also equipped with a functional seat belt. According to coworkers in the area at the time of the incident, lighting was sufficient and there were no environmental conditions which would have contributed to the incident. The road surface was dry and level asphalt. According to the coworker who was riding on the forks at the time of the incident, there were no obstructions in the travel path of the forklift which would have caused the victim to veer to the right, thus striking the pole. The area where the incident occurred was very open with no visual or physical obstructions. Also, the victim had driven forklifts in this area for the past four and a half years.

CAUSE OF DEATH:

The cause of death as stated on the death certificate was multiple internal injuries.

RECOMMENDATIONS/DISCUSSION:

Recommendation #1: **Personnel should comply with all requirements of their company's Injury Prevention Program, specifically the requirement to wear seat belts while operating forklifts.**

Discussion: This company has well-documented safety policies. They even provide each employee with an Employee Safety Handbook. This handbook has a section on lift truck safety rules. The handbook states "Use the seat belt provided on the lift truck. If the truck rolls over, hold on tightly. The seat belt will help protect you from being seriously injured. Without the belt, you could be thrown under the massive weight of the lift truck." Had the victim had his seat belt on, in accordance with company policy, this fatality might have been avoided. The forklift operators the FACE investigator spoke with all said they were aware of the requirement to wear seat belts but they all said they did not routinely use them.

Recommendation #2: **Employers should retrofit all forklifts in the company with seat belts.**

Discussion: Even though company policy requires seat belt use on the forklifts, only two of the four forklifts on the site at the time of the incident were equipped with seat belts. Companies should survey all locations where forklifts are used and ensure seat belts are installed on all forklifts.

Recommendation #3: **Employers and employees must ensure unauthorized personnel do not ride on forklifts.**

Discussion: The company Employee Safety Handbook states, "Passengers are not allowed to ride anywhere on the lift truck, including the forks." In addition to company policy 29CFR 1910.178(m)(3) states, "Unauthorized personnel shall not be permitted to ride on powered industrial trucks." The coworker, who was riding on the forks at the time of the incident, was facing the victim and having a conversation with him. This could have possibly obstructed the victim's vision as well as distracted him from safe operation of the vehicle. Had the coworker not been riding on the forks the victim should have been able to focus his full attention on operating the forklift.

Recommendation #4: Employers should consider implementing a spot inspection program to ensure all employees are complying with safety requirements and develop and enforce consequences for noncompliance.

Discussion: To ensure safety program compliance, spot inspections by supervisors and management should be conducted regularly to verify proper procedures are being followed. In this particular case, evening activities should be monitored, on an unannounced basis, by management personnel who normally work the day shift. Deterrent consequences should be established for noncompliance with the employer's Injury Prevention Program safety requirements. To be effective these consequences should be written as a part of an employer's Injury Prevention Program and must be enforced when violations are detected. This company's Employee Safety Handbook states, "Failure to follow safety rules and /or safe practices will result in disciplinary action, up to and including termination." However, there was no documentation that personnel had been disciplined for not wearing a safety belt while operating a lift truck. An effective Injury Prevention Program should instill an attitude in everyone that safety will never be compromised for expediency.

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