Stocker/Order Picker Dies After 12-Foot Fall From An Elevated Pallet–South Carolina

FACE 9402

SUMMARY

A 25-year-old male stocker/order picker (the victim) died after falling 12 feet to a concrete floor. The victim was re-stocking the third tier of a row of 36-inch-wide steel shelving units while working from a 47 ½-inch-long by 40-inch-wide pallet supported by a cherry picker. A co-worker, facing away from the victim, was opening boxes of merchandise at floor level on the same row. The victim was wearing a safety belt, and a permanently affixed 5-foot nylon lanyard was attached to the cherry picker's falling-object protective structure, above the victim; however, the victim had not attached the lanyard to his safety belt. As the victim was stepping from the shelving to the pallet, he lost his balance and fell backward off the pallet, 12 feet to the concrete floor below, landing on his back and striking his head. The co-worker, hearing the victim fall, ran to him and found him semiconscious but breathing. The co-worker alerted the shift supervisor, who summoned the emergency medical service (EMS) by phone. The EMS transported the victim to the local hospital where he died 5 days later. NIOSH investigators concluded that, to prevent similar occurrences, employers should:

- **ensure that workers continually adhere to the safe work practices 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 September 15, 1993, a 25 year-old male stocker/order picker died from injuries he received in a 12-foot fall from an elevated pallet on September 10, 1993. On September 30, 1993, officials of the South Carolina Occupational Safety and Health Administration (SCOSHA) notified the Division of Safety Research (DSR) of this fatality, and requested technical assistance. On December 21, 1993, a DSR safety specialist conducted an investigation of this incident. The incident was reviewed with employer representatives, the coroner, and the SCOSHA compliance officer assigned to the case. Photographs of the incident site taken immediately following the incident were reviewed during the investigation.

The employer was a multistate retail merchandise distributor that had been in operation for 40 years and employed 16,000 employees. Two hundred thirty-five workers were employed at the facility where the incident occurred, including 11 stocker/order pickers. The employer had a comprehensive safety program. Each new employee received an employee handbook and a "Think Safety" pamphlet that contained general safety rules. New employee orientation was conducted under the direct supervision of the shift supervisor until such time that the supervisor felt the employee could perform the job correctly. Employees received training on such topics as the correct use of personal protective equipment and proper

lifting techniques. Safety inspections were conducted daily by the shift supervisor on all three shifts, weekly safety meetings were conducted for all personnel, and all personnel received yearly hazard awareness training. Cherry picker operators received 3 days of specialized training from the shift supervisor before operating the machines on their own. The victim had been employed at the facility for 2 months. This was the first fatality experienced by the employer.

INVESTIGATION

The retail distribution center operated on three shifts–7 a.m. to 3:30 p.m., 2:30 p.m. to 10:30 p.m., and 10:30 p.m. to 6 a.m. Goods, such as non-perishable foods, household items, and various other items were received from the manufacturer and warehoused. The merchandise was stored on rows of 3-tiered steel shelving. The top shelf was 12 feet above floor level and the rows were located 102 feet apart. When orders were received, the merchandise was pulled from the warehouse, transferred to a truck, and then shipped to the desired destination.

On the day of the incident, the victim and a co-worker were re-stocking shelves on the 10:30 p.m. to 6 a.m. shift. They began the shift by loading the first batch of merchandise brought to the warehouse on pallets. Two sizes of pallets were used (472" by 40" and 30" by 38"). At approximately 1 a.m., they began to stock the shelves. The co-worker raised the victim on a loaded pallet to the top shelf using a cherry picker, then left the cherry picker and began to load more pallets at floor level. The victim was wearing a safety belt that was required, by company policy, to be attached to a 5-foot nylon lanyard that was permanently affixed to the cherry picker's falling-object protective structure above him. A sign, warning workers to keep the lanyard attached to their safety belt at all times, was posted on the cherry picker. It could not be determined if the lanyard had been attached to the victim's safety belt at this time. The men continued this activity until the first batch of merchandise was warehoused.

At approximately 4 a.m. the men began to stock the second batch of merchandise. When the second batch of merchandise was warehoused, the co-worker raised the victim on an empty 472" by 40" pallet to the top shelf to pull goods to fill an order. He then turned away from the victim and began to load pallets on the same row, approximately 20 feet from the cherry picker. As the co-worker was loading a pallet he heard a sound and turned to see the victim lying on his back on the concrete floor. The co-worker ran to the victim and found him semiconscious but breathing. The co-worker alerted the shift supervisor, who called the emergency medical squad (EMS). The EMS arrived on the scene 12 minutes later and transported the victim to the local hospital where he died 5 days later.

The victim apparently lost his balance as he was loading the pallet and fell backward off the pallet. The victim was wearing his safety belt but was not attached to the lanyard. An examination of the lanyard showed it to be free from defects.

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, the victim was wearing a safety belt but did not attach the permanently affixed lanyard to it as required by company safe work procedures and as taught in new employee orientation.

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 was working without being attached to the lanyard, in violation of established safety rules. Workers and co-workers should look out for

one another's safety and remind each other of the proper way to perform their tasks. 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: Although the shift supervisor conducted a safety inspection during each shift, additional scheduled and unscheduled safety inspections should be conducted by a competent person to ensure that company safe work procedures are being followed. No matter how comprehensive, a safety program cannot 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 and to the prevention of occupational injury.

Competent person: One who is capable of identifying existing and predictable hazards in the surroundings or working conditions which are unsanitary, hazardous, or dangerous to employees, and who has the authority to take prompt corrective measures to eliminate them.

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