Indiana State Department of Health
Indiana FACE 96IN14901
Date: December 06, 1996

TO: Charles L. Barrett, M.D., M.S.P.H., Medical Epidemiologist
Epidemiology Resource Center

FROM: Richard L. Warren, Indiana FACE Investigator

SUBJECT: Laborer killed when forklift falls off loading dock

SUMMARY:

On November 25, 1996, a 41-year-old male laborer (the victim) died from injuries sustained when the forklift he was operating fell off the loading dock pinning him under the roll over protection system (ROPS). The forklift did not have seat restraints. The incident was unwitnessed but evidence suggests the victim was unloading Gaylord recycling boxes off the back of a pickup truck. These boxes were 36" x 30" x 48" in size, weighed between 50 and 150 pounds and were on 48" x 40" wood pallets. The loading dock was 31 feet 6 inches long and 101 inches wide, had large cracks in the surface, and was in need of extensive repair. It was pouring down rain when the victim came out of the storage building for his last load. Evidence indicates that either the victim's forklift was too close to the outer edge of the loading dock which crumbled, or the right front tire got caught in a large crack in the surface causing the forklift to tip over. The victim was pinned underneath the ROPS of the overturned forklift.

The Indiana FACE investigator concluded that to prevent similar occurrences employers should:

1. Ensure passageways are kept clean and in good repair where mechanical equipment is used.

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2. Ensure employees receive the proper lift truck operator safety training.

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3. Ensure employees maintain daily maintenance and safety checks on forklifts.

INVESTIGATION:

The investigation of this work- related fatality was prompted by the Indiana Occupational Safety and Health Agency (IOSHA). Information was obtained from employer interviews, coroner interviews and the IOSHA compliance officer. Pictures and measurements were taken at the scene. The company is in the

curbside recycling business and has been contracted by the city for 6 years. The company has been at this leased storage facility for two years. The company has three employees including the employer. The victim had worked 5 years for the company. The employer does not have a written safety policy and the employees have not had any kind of training on forklift safety. This is their first fatality.

CAUSE OF DEATH:

The cause of death as stated by the county coroner is traumatic asphyxia due to industrial accident.

RECOMMENDATIONS AND DISCUSSION

RECOMMENDATION # 1: Employers should ensure passageways are kept clean and in good repair where mechanical equipment is used.

DISCUSSION: The employer in this incident has been at this location for two years. The loading dock in question was in need of repairs with large cracks in the surface and crumbling cement edges. On the day of the incident it was pouring down rain when the victim was trying to unload the pickup. Water was pouring off the roof and, with the dock edges unmarked, might have contributed to the problem. When the FACE investigator and IOSHA arrived on the scene the loading dock had been removed. (This was IOSHA'S second visit and the first for FACE.) 29 CFR 1910.176 (a) states: "Where mechanical handling equipment is used, sufficient safe clearances shall be allowed for aisles, at loading docks, through doorways and wherever turns or passage must be made. Aisles and passageways shall be kept clear and in good repair, with no obstruction across or in aisles that could create a hazard. Permanent aisles and passageways shall be appropriately marked."

RECOMMENDATION # 2: Employers should ensure employees receive the proper lift truck operator safety training.

DISCUSSION: The employer in this case did not have a written safety policy for his employees and did not provide any formal training on forklift safety. 29 CFR 1910.178 l, operator training, states: "Only trained and authorized operators shall be permitted to operate a powered industrial truck. Methods shall be devised to train operators in the safe operation of powered industrial trucks."

RECOMMENDATION #3: Employers should ensure employees maintain daily maintenance and safety checks on forklifts.

DISCUSSION: Maintenance on the forklift involved in this incident was done only if there was a mechanical problem. 29 CFR 1910.178 q (7) states: "Industrial trucks shall be examined before being placed in service, and shall not

be placed in service if the examination shows any condition adversely affecting the safety of the vehicle. Such examination shall be made at least daily." According to the General Duty Clause of the Occupational Safety and Health Act (section 5 (a) 1), employers are required to provide a safe and healthy workplace for employees. To do so, employers must regularly survey the workplace to identify hazards. All identified hazards must be adequately addressed through engineering control measures or changes in work practices. Employers should instruct each employee in the recognition and avoidance of unsafe conditions. In this and similar situations, the employer may need to provide additional training to employees to understand the hazards and how to properly use equipment.

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What is the FACE Program?

FACE is one of many prevention programs conducted by the Indiana State Department of Health (ISDH). FACE stands for "Fatality Assessment and Control Evaluation." The purpose of FACE is to identify factors that increase the risk of work-related fatal injury. Identification of risk factors will enable more effective interventions to be developed and implemented. The FACE Program does not just count fatalities. It uses information gained from each fatality investigation to develop programs and recommendations aimed at preventing future occupational fatalities.

Who can you contact for additional information?

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