Indiana State Department of Health
Indiana FACE 96IN06601
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TO: Charles L. Barrett, M.D., M.S.P.H., Medical Epidemiologist
Epidemiology Resource Center

FROM: Richard L. Warren, Indiana FACE Investigator

SUBJECT: Yard-worker dies after forklift dropped a unit of wafer board on him while he was stacking and straightening lumber.

SUMMARY:

On June 4, 1996, a 16 year-old male yard-worker (the victim) died after a 4,320 pound unit of wafer board fell on him at the home service center where he worked. The victim and a co-worker were stacking and straightening lumber behind three stacked units of wafer board totalling 9 feet 4 inches in height and 8 feet in width. A forklift approached from the opposite side of the stacked wafer board for the purpose of retrieving the top unit. The forklift operator did not see the victim and co-worker because the wafer board blocked his view. As he attempted to lift the top unit off the stack, it became dislodged and fell forward onto the victim. The forklift operator immediately went to the aid of the victim who was found under the wafer board semi-conscious but breathing. A local emergency medical service (EMS) provider was called and responded promptly to the scene. The victim was transported to a hospital where he died the same day. The FACE investigator concluded, in order to prevent similar incidents, employers should:

1. Ensure that workers continually adhere to the safe work procedures that have been established by the employer.

a)

2. Encourage all employees to actively participate in workplace safety.

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3. Routinely conduct scheduled and unscheduled worksite safety inspections.

INTRODUCTION:

On June 4, 1996, a 16-year-old male yard-man (the victim) working at a home center died after a unit of wafer board fell on him while he was stacking and straightening lumber with a co-worker. Later the same day, officials from the Indiana Occupational Safety and Health Administration (IOSHA) notified the Indiana FACE program of this fatality and asked if we wanted to do our investigation along with IOSHA. On June 5, 1996, a representative from IOSHA, the FACE investigator and employer representatives met at the employer's premises to review the incident. Initial interviews were done at this time with company officials and witnesses. The fatality site was inspected and photographs and measurements were taken.

The employer in this incident is a home center with a lumber yard in the rear of the establishment. The employer has been in business for 23 years and employs 100 full-time and 8 part-time employees. This was the first fatality experienced by the employer.

The company safety program consists of spoken communication of safe work procedures presented to new employees. The company's forklift policy consists of watching a video on forklift safety and taking a written test. Forklift operators are certified by the company. The operations manager is responsible for enforcing the safety rules on work activities, use of personal protective equipment (PPE), and forklift safety.

INVESTIGATION:

Orientation for newly employed yard-workers is provided by the operations manager at the beginning of the work day. The employees usually start work at 7:00 a.m. when they are taken by the operations manager to the gate house ("dispatch") to obtain the days work tasks. Safety procedures are verbally presented at this time. New employees are usually paired with an experienced co-worker.

Yard-workers are required to straighten and stack lumber and clean the area for 2 hours every morning. Upon completing the assigned work tasks they report back to dispatch (gate house) to help customers and load purchases.

June 4 was the victim's first day at work. He was assigned with a co-worker who was employed only 5 days before the fatal incident. They started at the north end of Building 3, straightening and stacking lumber. About 30 minutes later, after straightening the lumber at the north end of Building 3, the victim and co-worker moved to the south end of the same building to continue their work assignment. At the time of the incident the victim and co-worker were straightening and stacking 2"x 4" x 12' pieces of lumber adjacent to three stacked units of wafer board which totalled 9 feet 4 inches in height and 8 feet in width. Each unit of wafer board weighed 4320 lb and consisted of 86 sheets measuring 4' x 8' x 7/16". Spacers of 2"x 4" x 4' lumber were placed between the units to allow forklifts to remove the units from the stack.

A forklift approached from the opposite side of the stacked wafer board for the purpose of retrieving the top unit. The forklift operator did not see the victim and co-worker because the wafer board blocked his view. As he attempted to lift the top unit off the stack, it became dislodged and fell forward onto the victim.

The forklift operator involved in this incident had been employed by the company for three months. Two months before the incident, he had been certified by the company to drive forklifts. On the day of the incident the forklift operator was building his second load from his work sheet and needed 25 sheets of wafer board. He came around the south side of Building 3 from the west and drove up a

slight incline to the three stacked units of wafer board. Because his view into the building was completely blocked by the wafer board he did not see the victim and co-worker stacking and straightening lumber. In his first attempt to remove the top unit of wafer board he could not get the forks completely under the load. The forklift operator stated that on the second attempt he thought he only got the forks 3/4 of the way under the load. Evidence suggests that as he was attempting to lift and remove the top unit from the stack, it started to wobble and fell forward on the victim. The forklift operator immediately jumped off the forklift and ran to the victim's aid. Finding the victim under the wafer board and lumber, he ran to the gate house to call a local emergency medical service (EMS) provider. EMS personnel arrived in about 6 minutes and found the victim semi-conscious and breathing. The victim was transported to a hospital were he died the same day.

CAUSE OF DEATH:

The medical report listed the cause of death as massive internal chest injuries.

RECOMMENDATIONS AND DISCUSSION

RECOMMENDATION # 1: Employers should ensure that workers continually adhere to the safe work procedures that have been established by the employer.

DISCUSSION: Employers should continually stress the importance of adherence to established safe work procedures. In this incident, evidence indicates that a verbal warning was needed to alert the forklift operator that co-workers were working unobserved in the path of his forklift. The evidence also indicates that the forklift operator did not know the co-workers were there and thus did not take measures to avoid this tragedy. As a result of this incident, the employer is now working on job descriptions and safety procedures for all employees.

RECOMMENDATION # 2: employers should encourage all employees to actively participate in workplace safety.

DISCUSSION: Employers should ensure that all workers understand the role they play in the prevention of occupational injury. In this incident, it was the victim's first day on the job as a yard-worker and he was assigned with a co-worker having only 5 days work experience. Evidence strongly suggests that both safety education and written safety policies were inadequate. Workers should be made aware that when they observe hazardous conditions or activities, they should, depending on the circumstances, notify management and/or remind co-workers of the proper way to perform their tasks and protect themselves. 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: Employers should be aware of any potential hazards or unsafe work conditions or practices in the workplace and should take an active role to eliminate them. Scheduled and unscheduled safety inspections should be conducted by a competent person (that is, 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). Even though these inspections do not guarantee the prevention of occupational injuries, they may identify hazardous conditions and activities that should be rectified.

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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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