Overturned forklift – Inspection #1016891

A **31 year old male** temporary employee was operating a forklift truck carrying a cardboard box of tobacco waste to a dumpster. He emptied the waste in the first dumpster, and then traveled with the mast up toward the second dumpster to dispose of the box when the truck tipped over crushing him between the ground, and the truck. The victim was operating a counterbalance Linde H25CT LP-gas forklift. The forklift had an 895 lb. Cascade 25D-MC-66Q carton hydraulic pressure clamp attachment which picks up boxes, and bales of tobacco that can't be picked up with forks. The victim had taken a cardboard box full of tobacco stems to a dumpster located outside on the south side of the building. According to a coworker, the victim had pulled up to the dumpster, raised his box up over the top edge of the dumpster, and cut two straps to allow the waste to fall into the dumpster. During this operation, the forklift operator releases just enough pressure off of the box to allow the waste to fall out of the bottom, but still hold on to the box itself. After the waste was dumped, he backed up, and started driving forward towards the second dumpster, located on the west side of the building to dispose of the cardboard box. The victim did not lower his mast before starting to drive towards the second dumpster. He traveled approximately 78 feet with the top of his mast/clamp approximately 15 feet high. As he approached the second dumpster, and turned toward it, the forklift tipped over due to the weight of the clamp being up in the air. The victim was thrown from, or jumped from, the forklift; he was not wearing his seatbelt. The victim did not have his load as far down as possible, and only raised enough to clear the ground. Having the mast/clamp raised up 15 feet high moved the forklift's center of gravity, and made the forklift top heavy. Since the forklift was top heavy, it tipped over when the victim turned the steering wheel towards the dumpster. The victim was crushed between the ground, and the forklift. The victim was fatality injured due to crushing injuries to his legs, abdomen, and head.

Citation(s) as Originally Issued

A complete inspection was conducted at the accident scene. Some of the items cited may not directly relate to the fatality.

Citation 1 Item 1

TCA 50.3.105(1)	Each employer did not furnish to each of its employees conditions of employment and a place of employment free from recognized hazards that are causing or are likely to cause death or serious injury or harm to its employees. In that the employer did not ensure that an employee operating a Linde H25ct LP-gas forklift wore his seatbelt at all times while operating the forklift.

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Citation 1 Item 2

29 CFR 1910.146(g)(1)	The employer did not provide training so that all employees whose work is regulated by this section acquire the understanding, knowledge, and skills necessary for the safe performance of the duties assigned under this section. In that the employer did not ensure that employees who enter confined spaces such as ordering drums received training on confined space entry.

Citation 1 Item 3a

29 CFR 1910.147(c)(4)(i)	Procedures were not developed, documented, and utilized for the control of potentially hazardous energy when employees are engaged in the activities covered by this section. In that the employer did not have machine-specific lockout/tagout procedures in place for employees to follow when performing servicing/maintenance work on equipment, such as unjamming the thrashers and cleaning inside of the ordering drums.

Citation 1 Item 3b

29 CFR 1910.147(c)(5)(ii)(D)	Lockout devices and tagout devices did not indicate the identity of the employee applying the device(s). In that the employer did not ensure that locks used for lockout/tagout were identifiable. The locks were not marked in any way to identify the employee who applied it.

Citation 1 Item 3c

29 CFR 1910.147(f)(3)(ii)(D)	Each authorized employee did not affix a personal lockout or tagout device to the group lockout device, group lockbox, or comparable mechanism when he or she begins work. In that the employer did not ensure that each individual employee performing servicing/maintenance work applied their own lock when a group of employees was performing the work.

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Citation 1 Item 4

29 CFR 1910.178(n)(7)(iii)	On all grades the load and load engaging means were not tilted back if applicable, and raised only as far as necessary to clear the road surface. In that the employer did not ensure that an employee operating a Linde H25CT LP-gas forklift traveled with the load down as far as possible and raised only enough to clear the ground. The load consisted of an 895 lb. Cascade 25D-MC-66Q carton clamp attachment and a cardboard box. The employee traveled 78 feet between two dumpsters with the top of the mast and clamp approximately 15 feet high.

Citation 1 Item 5

29 CFR 1910.305(b)(1)(ii)	Unused openings in cabinets, boxes, and fittings were not effectively closed. In that the 480 volt electrical panel in the Scrap Cleaning Department had 3 unused openings (13, 15, 17) that were not effectively closed.

Citation 2 Item 1

29 CFR 1910.146(c)(7)(iii)	The employer did not document the basis for determining that all hazards in a permit space have been eliminated, through a certification that contains the date, the location of the space, and the signature of person making the determination. In that the employer did not ensure that written documentation was filled out each time an ordering drum, which is a permit-required confined space, was re-classified to a non-permit required confined space through lockout/tagout.

Citation 2 Item 2

29 CFR 1910.178(q)(7)	Where industrial trucks are used on a round-the-clock basis, they were not examined after each shift. In that the employer did not ensure that forklifts were inspected prior to use on night shift. The forklifts were being inspected prior to use on day shift only.

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Citation 2 Item 3

29 CFR 1910.215(b)(9)	The distance between the wheel periphery and the adjustable tongue or the end of the peripheral member at the top exceeded one-fourth inch. In that the tongue guard on the Dayton bench grinder was not adjusted properly. The distance between the tongue guard and the abrasive wheel was 5/8 inch.

Citation 2 Item 4

29 CFR 1910.303(b)(2)	Listed or labeled equipment was not installed and used in accordance with any instructions included in the listing or labeling. In that an Ace 6-outlet relocatable power tap (RPT) in the Maintenance Shop was not used and installed per the listing/labeling instructions in the following instances: a) The RPT was attached to a worktable with screws. The RPT is not intended to be permanently secured to any surface. b) The RPT was being used in a maintenance shop where it could be damaged by dirt and chemicals and overloaded with high-amperage equipment. The RPT is designed to be used in a home/office environment to power items such as computers and audio/video equipment.

Citation 2 Item 5

29 CFR 1910.305(g)(2)(iii)	Flexible cords and cables were not connected to devices and fittings so that strain relief is provided that will prevent pull from being directly transmitted to joints or terminal screws. In that the flexible cord on the 120 volt DeWalt D28770 band saw did not have adequate strain relief.

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Photo 1 of 2 – Forklift on its side with the attachment in the raised position

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Photo 2 of 2 – Forklift on its side with the attachment in the raised position