29 Heat Exhaustion—Insp # 1694161 **Kroger Co.**

A 59 year old male employee was found on his forklift unresponsive after working in the Salvage Department for a couple of hours at the start of his shift.

According to company officials the victim worked in the Salvage Department aka Salvageables for a couple of hours at the start of his shift and then drove his propane powered forklift over to the Perishable Department where he worked for approximately 45 minutes before being found slumped over on the forklift. Representatives informed that the employee mentioned to the Supervisor that he had not been feeling well.

In the Salvage Department, according to the employer, the victim performed unloading of trucks that contained damaged product that had been returned to the facility or product that would be donated to a food bank. It was revealed that the Salvage Department was not air conditioned but had air-conditioned Break Rooms that were used as cooling rooms. The Perishables Department was air conditioned. Representatives informed that the victim may have been going back and forth between both departments in an attempt to cool off.

It was revealed during the inspection that the victim started his shift around 4:00pm and had not been working long before the incident occurred; he was discovered at approximately 8:11pm.

A review of several videos was conducted onsite and according to the footage at approximately 4:09pm the victim was observed arriving to work in dark colored clothing. He was seen in the break area located in the Salvage Department. Then at approximately 7:16pm the victim was seen operating a forklift next to dock door #312. A cooler was shown in the video near dock door #319. At approximately 7:42pm, the victim was observed in the video on a forklift near dock door #149 which is located in Perishables. The victim was standing on the forklift and resting on his arms. The employee was seen again on the video at approximately 7:49pm when he stepped off the lift and took a seat where he once stood on the forklift. At approximately 8:00pm, a supervisor was seen walking looking towards the side of the forklift on which the victim was sitting but continued walking. At approximately 8:11pm an employee discovered the unresponsive victim.

Company officials were not for certain which forklift the victim was operating at the time of the incident; however, based on the video it was one of two Crown electric lifts. Both forklifts were observed onsite and no deficiencies were found with the forklifts.

Interviews revealed that employees working in the Salvage Department performed tasks such as moving pallets of damaged product from one trailer, sorting it, and place it onto another trailer. Employees also cleaned trailers.

Employees working in the Freezer and Perishables Departments were working on production, potentially rewarded for the amount of product they moved. However, there were no production driven tasks for employees working in the Salvage Department. Employee interviews revealed employees in Salvage could take a break whenever needed.

Employees working in the Salvage Department informed that they were exposed to heat in the workplace in the summer months as there is no air condition on the Salvage dock. Interviews indicated that there were fans, water, and popsicles available. Interviews also indicated that employees have also been provided cooling towels. According to employee interviews, employees in the Salvage Department were instructed to rest/cool off if they felt hot. There was no work/rest regimen established and implemented by the company in efforts to reduce heat related illnesses.

It was revealed that the company had a Heat Stress Awareness program in place. However, the Health and Safety Manager, informed that the company's heat stress Awareness program was newly developed, and training in heat stress awareness had only been provided to new hires during new hire orientation in March 2023. No other employees had been trained. It was also revealed that outside temperatures in the city were monitored via the Weather Channel and that heat advisory information was typically communicated to employees during huddles.

The medical records obtained from the medical examiner's office and hospital did not provide definitive evidence that heat was for certain a factor in the incident involving the victim. Interviews revealed that the victim did not seem to be himself when he arrived to work and he did not inform anyone of signs or symptoms of a heat related illness. Medical records revealed the cause of death was attributed to atherosclerotic and hypertensive cardiovascular disease noting that possible environmental heat exposure may have been a contributing condition.

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 1a **Type of Violation: Serious** **$2000**

29 CFR 1910.36(d)(1): Employees were not able to open an exit route door from the inside at all times without keys, tools, or special knowledge:

On 08/28/2023, the exit route door on the Freezer Dock between Perishables and the Freezer Department was blocked by the storage of plastic pallets.

Citation 1 Item 1b **Type of Violation: Serious** **$0**

29 CFR 1910.37(a)(3): Exit route(s) were not kept free and unobstructed:

On 09/05/2023, section 48 exit door located in the Freezer Department was obstructed by ice accumulation.

Citation 1 Item 2a **Type of Violation: Serious** **$2400**

29 CFR 1910.119(n): The employer did not establish and implement an emergency plan for the entire plant in accordance with the provisions of 29 CFR 1910.38. In addition, the emergency action plan did not include procedures for handling small releases:

The emergency action plan established by the employer did not contain all of the provisions required by 29 CFR 1910.38 to address employee actions to take during an unwanted release of anhydrous ammonia. In addition, the plan did not contain procedures for managing small anhydrous ammonia releases.

Citation 1 Item 2b **Type of Violation: Serious** **$0**

29 CFR 1910.38(f)(1): The employer did not review the emergency action plan with each employee covered by the plan:

The emergency action plan established by the employer was not reviewed with each affected employee. Employees could be exposed to anhydrous ammonia in the event of unwanted ammonia release to employee work areas.

Citation 1 Item 3a **Type of Violation: Serious** **$2000**

29 CFR 1910.1200(h)(1): Employees were not provided effective information and training on hazardous chemicals in their work area at the time of their initial assignment and whenever a new hazard that the employees had not been previously trained about was introduced into their work area:

Employees had not been provided effective training on anhydrous ammonia, which they could be exposed to in the case of a foreseeable emergency.

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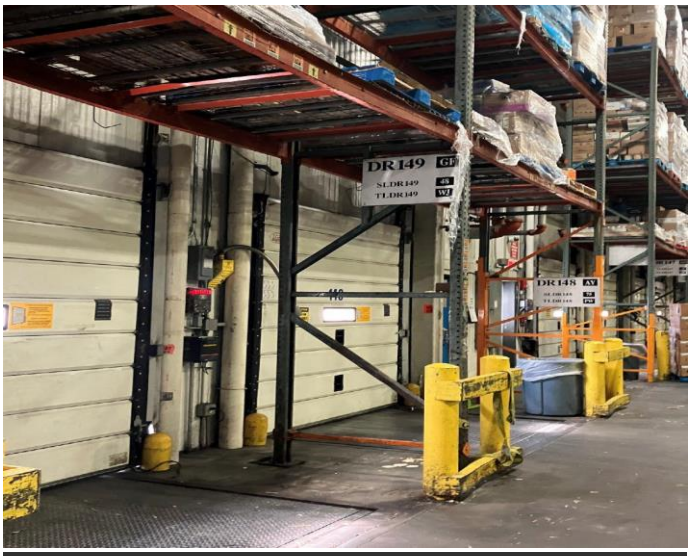

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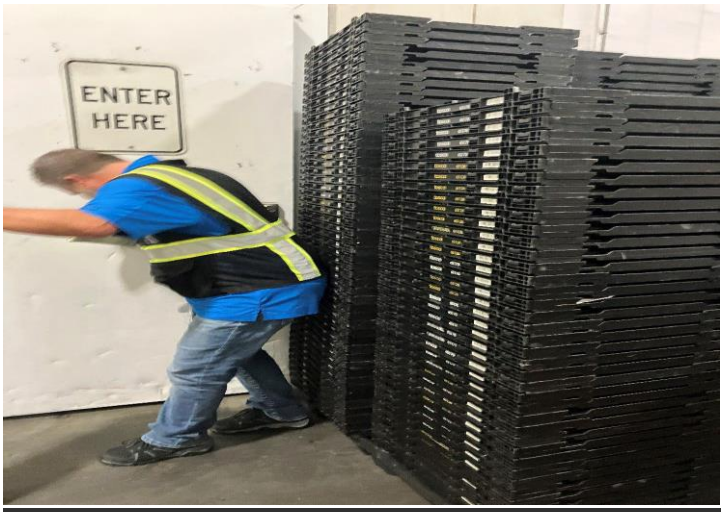

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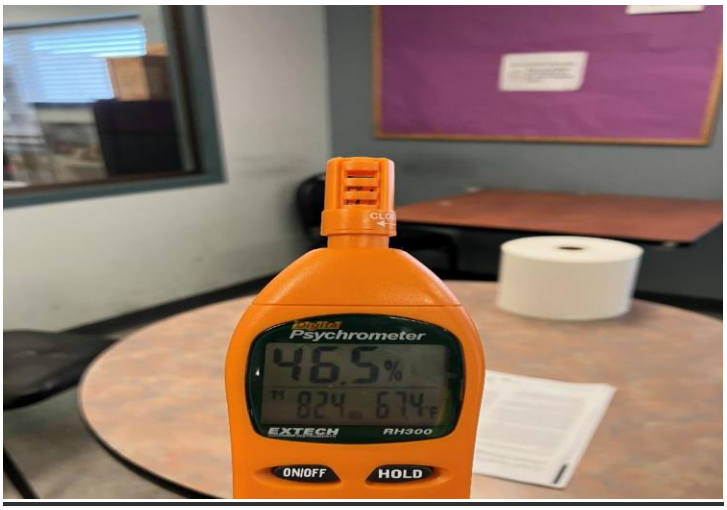

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