PREVENTING FORKLIFT FATALITIES

The California Fatality Assessment and Control Evaluation (FACE) program has been investigating work-related deaths since 1992. The goal of the FACE program is to prevent these deaths by informing workers and managers of worksite hazards and how to avoid them. The two incidents below involve forklift operators who died when their forklifts rolled and pinned them against large objects. Both operators parked their forklifts on concrete surfaces with small inclines. The operators did not set their parking brakes before getting off of the forklifts.

THE UNAWARE TRUCK DRIVER

A 39-year-old truck driver, Andreas P.*, died when he was crushed between a forklift and a flatbed trailer. Andreas had parked a forklift on a sidewalk slightly higher than his truck. He went to straighten some pallets on the trailer. The forklift rolled forward and pinned Andreas between the edge of the trailer and the mast of the forklift. Although Andreas was trained in forklift operation his employer did not make sure he followed forklift rules and regulations.

THE UNTRAINED OPERATOR

A 21-year-old warehouseman, George L.*, died when he was crushed between a forklift and the edge of the floor of a railroad boxcar. George drove the forklift to the loading area of a loading dock. After he parked it, he tried to open a boxcar door. The forklift rolled backwards toward the boxcar, and fell partially over the edge. This pinned George between the edge of the floor of the boxcar and the rear of the forklift. George was a new employee who was not trained in forklift operation.

Employers should make sure that:

- Forklift operators follow the rules when they get off a forklift.
- Forklifts are regularly inspected.
- No one stands between parked forklifts and large, unmovable objects.
- New employees are not allowed to do new tasks until they are properly trained and tested in forklift operation.

Manufacturers should:

- Make forklifts with automatic parking brakes so that the brakes engage whenever no one is in the seat.

* Not the victim’s real name

For complete fatality reports of these (96CA001 & 96CA016), or other cases, and additional information on the California FACE program, please contact: California Department of Public Health Occupational Health Branch (OHB), FACE Program 850 Marina Bay Parkway, Building P, 3rd Floor, Richmond, CA 94804 (510) 620-5757

California FACE program’s website (www.cdph.ca.gov/face)
CA Relay Service: 711 or (800) 735-2929 (hearing/speech impaired)

To obtain a copy of this document in an alternate format, please contact OHB at (510) 620-5757. Allow at least 10 days to coordinate alternate format services.
FACE stands for “Fatality Assessment and Control Evaluation.” The purpose of the FACE program is to identify hazards that may cause work-related deaths so that employers and employees can help prevent them.

FACE is a program run by the Occupational Health Branch within the California Department of Public Health, and funded by the National Institute for Occupational Safety and Health.