Crushed by---Insp #1518649 Lodge Manufacturing Company

A **49 year old male** employee was crushed when a stand-up forklift he was operating went off the edge of a loading dock and turned over on him. This is a warehouse and distribution site for Lodge Manufacturing Company which manufactures and sells iron cookware primarily. The facility is an approximately 212,000 square foot warehouse facility with 50 foot ceilings that included administrative offices, storage area, and a total of 24 dock doors for loading merchandise onto trucks for distribution.

On the day of the incident, there was one employee operating the sit-down electric forklift that picked merchandise from the rack system, 4 employees were using electric powered pallet jacks to transport the merchandise to the individual staging aisles in front of the dock doors, and three forklift operators were using stand up electric powered forklifts to load the trucks from the staging area. The facility was busier than normal on the day of the incident as the warehouse in Texas had previously been shut down due to COVID 19 and had recently reopened. Employee interviews indicated that on a normal day, operators would usually load approximately 20 trucks between both shifts combined. On the day of the incident, employees reported loading approximately 30- 40 trucks over the day.

On the day of the incident, the victim was operating the stand-up forklift all day loading trucks and at approximately 6:45pm he had completed loading a truck and was driving his lift to the office on the northeast corner of the dock area to turn in his paperwork. He did not have a load on his forks and was travelling west to east directly adjacent to the dock doors on the north side of his route. Video from the employer's security video shows that the victim travelled from approximately dock door 20 east toward the administrative offices until he approached dock door 4. He was driving the lift with the forks trailing and the operator side leading. The victim was standing at the controls with his back to the north and looking over his left shoulder as he steered the equipment. As he approached dock door 5, his lift appeared to drift to the north a little placing him closer to the openings of the dock bay rollup doors. Directly in front of dock door 4, his lift turned abruptly, and he drove through the open dock door and it immediately fell on its operator position side, crushing him on the ground below resulting in the fatality.

Interviews indicated that prior to the incident, the employees staging the inventory for the loaders would place pallets and boxes of merchandise this close would not allow forklifts room to maneuver the equipment without having to travel close to the dock doors.

According to employee interviews, the staging area between the facility rack system and the dock doors had expanded over the years of operation. It was demonstrated that the floor of the warehouse had faint traces of paint or tape lines that indicated that the inventory was to remain at least 14 feet from the opening of the dock, but the lines had become worn and not replaced. Instead, the inventory had become habitually placed at approximately 11 feet 3 inches from the door openings.

Employee interviews indicated that the overhead rollup doors of each of the 24 dock bays remained open most of the time, regardless of a truck being parked there or not. If it were cold outside, the doors would be closed to preserve heat in the building; but otherwise, they were routinely left open. There was no form of guarding at the door openings to protect the employees from inadvertently falling out the door.

A third-party company recovered the damaged lift and inspected it for defects and damage caused by the incident. The report indicated that the steering and brakes were intact, operational and within specs. Training records indicated that the victim had recently been re-trained and evaluated. The inspection records indicated that the forklift had been inspected pre-shift on the day of the incident.

Multiple interviews with coworkers indicated that the victim had recently been diagnosed with an unknown cardiac health issue. Even though his cardiac issues were referenced in the autopsy, the medical examiner indicated that he passed away due entirely to traumatic injuries incurred during the incident.

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 **Type of Violation:** **Serious** **$5400**

29 CFR 1910.178(m)(6): The employer did not ensure that safe distance was maintained from the edge of ramps or platforms while on any elevated dock, or platform or freight car.

In that employees were exposed to fall hazards due to limited space to operate forklifts directly adjacent to the 24 dock doors on the north wall of the facility as the merchandise that was staged for loading restricted the travel lane to approximately 10 feet and 8 inches.

Citation 2 Item 1 **Type of Violation:** **Other-than-Serious** **$525**

29 CFR 1910.28(b)(1)(i): The employer did not ensure that each employee on a walking-working surface with an unprotected side or edge that was 4 feet (1.2 m) or more above a lower level was protected from falling by one or more of the following: Guardrail systems, safety net systems, or personal fall arrest systems.

In that employees were exposed to fall hazards when working directly adjacent to unguarded dock platforms on the north wall of the warehouse that were greater than four feet above the lower level of the truck yard.

Citation 2 Item 2 **Type of Violation: Other-than-Serious** **$350**

29 CFR 1910.157(c)(1): Portable fire extinguishers were not mounted, located and identified so that they were readily accessible without subjecting the employees to injuries.

In that employees were exposed to fire hazards due to four fire extinguishers mounted on the north wall of the warehouse were not marked to identify their location.

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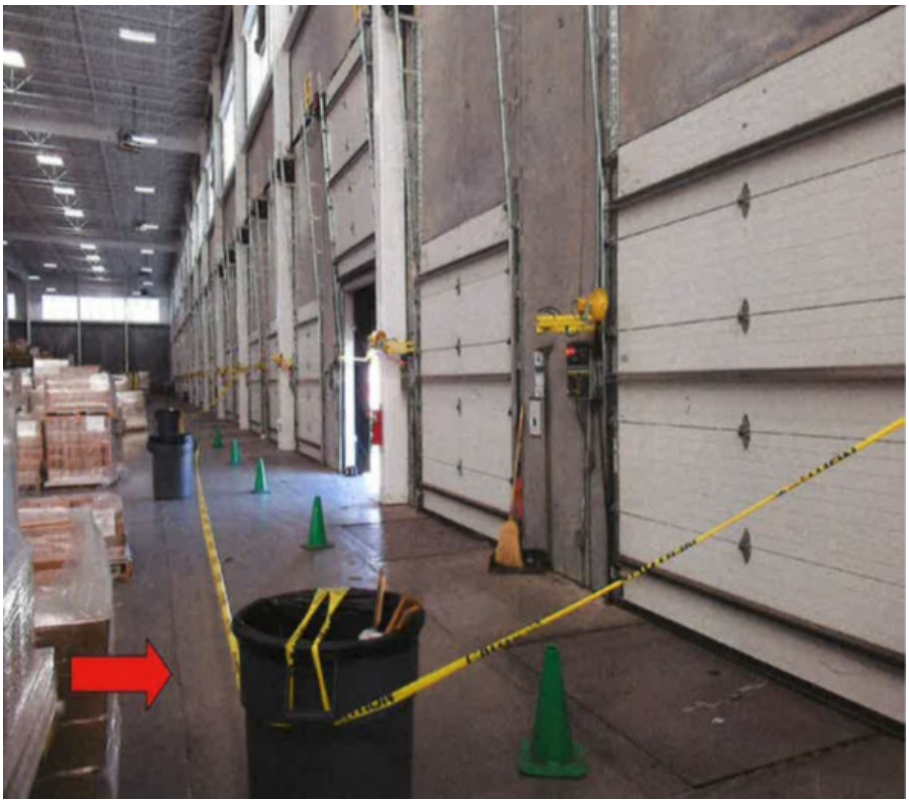

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