www.smartersafety.com.au

Source: WorkWise (State Coroner's Office and Victorian Institute of Forensic Medicine publication)

Forklifts Kill

Introduction:

A reduction in forklift-related deaths has occurred in Victoria over the past 20 years. From a peak of 8 forklift - related workplace deaths in 1988, no more than 2 deaths per year have occurred since 2005. This maybe credited largely to design solutions to protect both operators and bystanders. Such solutions include safe seating zones and restraints, designated traffic zones, maximum lifting heights and load limits, coupled with operator training and certification. Hazards within the work environment, such as pedestrian safety in areas of mobile machinery operation, can also be rectified through safe design.

Case Number: 0170-03: Incident Summary...

Mr R was a 46 year old male who was employed on a casual basis as a labourer. On the day of his death, Mr R was transporting a traction motor to a nearby location using a forklift. While travelling up an incline, the forklift tipped to the left and Mr R was crushed by the top of the roll cage as he attempted to jump clear. He died as a result of multiple injuries.

Investigation:

The coroner's investigation identified a number of key factors that contributed to the fatal incident. Mr R had used a lifting sling that was too long and had not effectively secured the traction motor. As a result, it was able to swing and shift the centre of gravity of the forklift to the left. Mr R had to operate the forklift up a slight incline, and approached this incline on an angle. The forklift arms were raised to three metres and were moved to the left to allow for clearer vision. The coroner commented that although this procedure was usual practice, it contributed to the forklift's centre of gravity shifting in this incident. Additionally, all of the forklift tyres were under-inflated which further contributed to the instability of the forklift.

Findings and Recommendations:

A member of the Victoria Police investigated the circumstances of Mr R's death and made the following recommendations, which were adopted by the coroner in his finding:

1. Seatbelts to be fitted to all forklifts to secure the driver;
2. "Wings" to be fitted to both sides of the forklift seat to prevent the driver falling out due to roll over;
3. Continuous safety training and bi-yearly assessments of persons using forklifts; and
4. Solid tyres to be used on forklifts instead of inflatable tyres.

The coroner also commented that Mr R 'was an experienced forklift driver...[whose] accident is one due to a combination of circumstances that unfortunately resulted in his death'.

Case Number: 3859-04: Incident Circumstances...

Master D, a 12 year old student, was playing at his father's workplace. Master D repeatedly requested an employee at the business to let him ride on a forklift. Finally giving in, he was allowed to sit on the forklift as a passenger while the employee operated the vehicle. Master D sat to the right side of the driver, just above the engine of the forklift. The vehicle was not designed to carry passengers. While the driver of the forklift was making a U-turn at the work premises, the accelerator was pressed by Master D, causing the wheel of the forklift to hit an open storm drain. Master D was thrown from the vehicle, caught between the forklift and brick wall, suffering fatal chest injuries.

Coronial investigation

The coroner stated that this was another case highlighting the dangers of using machinery and other industrial equipment for purposes other than for their intended purpose. The need for children to be accommodated appropriately when visiting workplaces was recognised by the coroner. Further, not only was the forklift not designed to carry passengers, it should never have been used as entertainment, especially for children visiting the workplace. The coroner recommended that WorkSafe Victoria give consideration to a public awareness campaign, highlighting the dangers of unsupervised children in the workplace, including the dangers presented by the inappropriate use of machinery, particularly forklifts.

www.smartersafety.com.au

Source: WorkWise (State Coroner's Office and Victorian Institute of Forensic Medicine publication)

Forklifts Kill

Case Number: 0108-00: Incident Circumstances...

A forklift operator was in the process of stacking crates from a shipping container onto the tray of a semi-trailer at a work premises. The driver of the truck was positioned on the opposite side of the trailer awaiting completion of the loading task. The truck driver was not instructed to move away from the operating area into a safe position, such as the truck cabin or tea room. The forklift operator commenced the loading procedure unaware of the truck driver's position due to a lack of visibility. The load inadvertently fell from the trailer and struck the truck driver, inflicting fatal injuries.

Coronial investigation:

A lack of strict supervision and workflow design to avoid pedestrians and forklift interaction in loading areas was recognised in the coroner's investigation. The coroner identified an absence of regular supervision of the loading operation by either the management of the premises or the transport company. The coroner also noted the forklift driver was not in possession of a Certificate of Competency to operate a forklift. Induction booklets were in the possession of both companies warning all staff of the dangers of personnel working in the vicinity of forklift operations. Both companies were aware of the risks associated with loading procedures, although neither had adopted specific work practices aimed at identifying hazards of work activities and managing the risks. As a result, no process was in place for supervising the work task and ensuring the separation of pedestrians from the vicinity of loading and unloading procedures.

Forklift seatbelts save lives!