

20. Thrown from Man Basket

A **43-year-old** Hispanic employee died when the personnel platform he was working from was ejected from the forks of a powered industrial truck. The victim and two co-workers were constructing a tree house on residential property. One of the co-workers operated the forklift and raised the victim up in the basket approximately 14 feet in the air to work on the tree house. The board the victim was putting up needed a one-half inch cut off, so the forklift operator turned the lift off, got out and received the board from the victim, leaving the victim in the basket raised above the ground. The forklift operator proceeded to the miter saw to cut the board. Suddenly he heard the victim and the other co-worker tell him that the forklift was moving. The vehicle rolled down a hill approximately 200 feet and struck a tree. When the forklift hit the tree, the basket came off the forks with the victim still in it, and the corner of the basket struck the victim in the head and landed on top of him. The forklift operator had not engaged the parking brake before he exited the lift because it was known to not disengage properly after being engaged. Furthermore, the basket had not been secured to the lift. The victim's injuries were fatal.

Citation(s) as Originally Issued

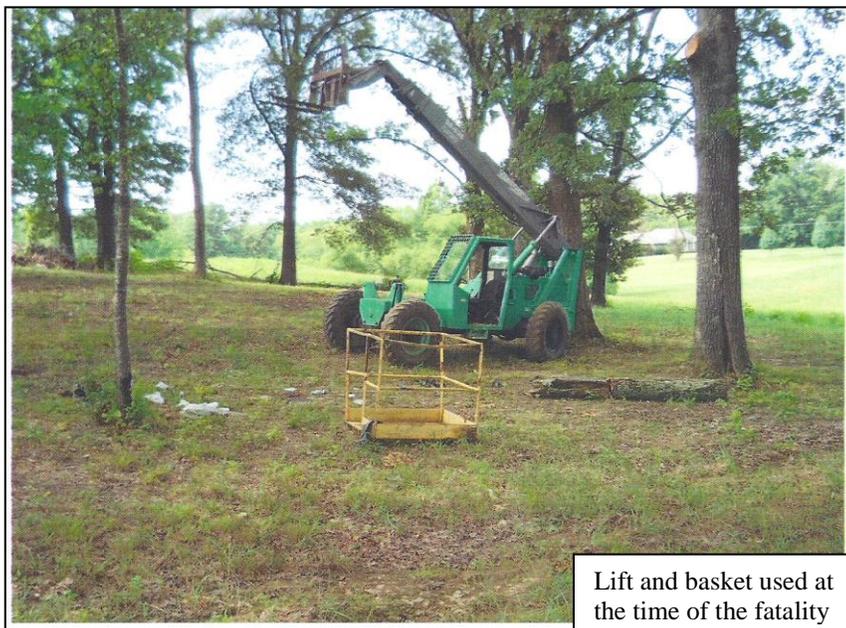
Citation 1

Item 1a 1910.178(l)(4)(iii)	An evaluation of each powered industrial truck operator's performance had not been conducted at least once every three years.
Item 1b 1926.454(a)	The employer did not have each employee who performs work while on a scaffold trained by a person qualified in the subject matter to recognize the hazards associated with the type of scaffold being used and to understand the procedures to control and minimize those hazards.
Item 2a 1926.20(b)(3)	The use of any machinery, tool, material, or equipment not in compliance with any applicable requirement of the TOSHA standards was neither identified as unsafe by tagging or locking the controls to render them inoperable or was not physically removed from its place of operation.
Item 2b 1926.600(a)(3)(ii)	Equipment was parked without the parking brake set.
Item 3a 1926.451(c)(2)(iv)	Front-end loaders and similar pieces of equipment were used to support scaffold platforms when they were not specifically designed by the manufacturer for such use.
Item 3b 1926.451(c)(2)(v)	Forklifts shall not be used to support scaffold platforms unless the entire platform is attached to the fork.

Citation 2

Item 1 1926.451(c)(2)	Supported scaffold poles, legs, posts, frames, and uprights were not bearing on base plates and med sills or other adequate firm foundations.
Item 2 1926.451(c)(2)(ii)	Unstable objects were used to support scaffolds or platform units.

Item 3 1926.451(f)(3)	Scaffold and scaffold components were not inspected for visible defects by a competent person before each work shift and after any occurrence which could affect a scaffold's structural integrity.
Item 4 1926.452(c)(2)	Frames and panels were not braced by cross, horizontal or diagonal braces, or combination thereof, which secure vertical members together laterally. The cross braces shall be of such length as will automatically square and align vertical members so that the erected scaffold is always plumb, level, and square. All brace connections shall be secured.
Item 5a 1910.1200(e)(1)	The employer did not develop, implement, and/or maintain at the workplace a written hazard communication program.
Item 5b 1910.1200(g)(8)	The employer did not ensure that safety data sheets were readily accessible to the employees in their work area and during each work shift for chemicals used.
Item 5c 1910.1200(h)(1)	Employees were not provided information and training on hazardous chemicals or materials in their work area at the time of initial assignment and whenever a new hazard was introduced into their work area.
Item 6 TDL Rule 0800-1-3-.05(1)(a)	An oral report of an employment accident resulting in a fatality or the inpatient hospitalization of three or more employees was not made within eight (8) hours after the occurrence to the nearest Area Office of the Division of Occupational Safety and Health or to the TOSHA toll-free central telephone number (1-800-249-8510).



Lift and basket used at the time of the fatality