BEFORE THE NORTH CAROLINA OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION

COMMISSIONER OF LABOR FOR
THE STATE OF NORTH CAROLINA,

COMPLAINANT,

v.

CENTRAL TRANSPORT, INC.,

RESPONDENT.

DOCKET NO. OSHANC 2005-4502
OSHA INSPECTION NO. 308655307
CSHO ID NO. B5670

ORDER

THIS MATTER was heard by the undersigned in Charlotte, North Carolina on four hearing days: November 16, 2005, February 2 and 3 and March 1, 2006.

The complainant was represented by Ralf F. Haskell, Special Deputy Attorney General; respondent was represented by Peter J. McGrath, Jr. of Moore & Van Allen, PLLC.

There were no preliminary matters to determine prior to the taking of evidence. At the conclusion of the hearing the parties were allowed to submit post-hearing briefs, which were due by April 15, 2006. On May 25, 2006 the complainant filed a motion to amend Citation 1, Item 1, an alleged violation of the General Duty Clause (N.C. Gen. Stat. §95-129(1). The proposed amendment alleges specific hazards in the use of powered industrial trucks (forklifts) which necessitate the use of available seat belts during the operation of such trucks. For reasons stated later in this Order, this motion to amend is allowed.

The respondent was issued a non serious violation of 29 CFR 1910. 141 (d)(2)(iv) for its failure to provide hand towels or other drying devices in four employee restrooms. The respondent did not contest this citation item.

After hearing and receiving the evidence, and considering the arguments of counsel as contained in their briefs, the undersigned makes the following

FINDINGS OF FACT

1. The complainant is charged by law with the responsibility for compliance with and enforcement of the provisions of the Occupational Safety and Health Act of North Carolina (the "Act").

2. The respondent is a corporation which operates a less than truckload (LTL) general commodities transportation service throughout North America, including North Carolina. The respondent has approximately 165 customer service centers (terminals).

3. On February 9 and 10, 2005 complainant's compliance safety officer (CSO) Cohen Elgin conducted a complaint inspection of respondent's truck terminal located at 601 Johnston Road in Charlotte, North Carolina.

4. The respondent's Charlotte terminal is approximately 130,000 square feet in size and consists, in pertinent part, of a large four (4) foot high loading dock with 182 open truck bays lining each side of the building; an interior warehouse or staging area for freight; a dock office; a battery charging station; an office area; and a separate shop building located across the parking lot from the terminal.

5. The terminal floor is concrete and on one side has an old steel monorail which runs along the floor near the open-sided bays. Sections of the monorail were bent up, while other sections were missing. Also, pieces of the concrete had been removed.

6. The Charlotte terminal is covered by a roof which overhangs the open-sided edges of the loading dock by approximately 10 feet. Despite this overhang, the dock floors occasionally get wet during rain storms. The floors will sweat; an amount of condensation or moisture would form on the cement surfaces during periods of inclement weather or high humidity. Dock sweating is a common place occurrence at respondent's facilities. Additionally, liquid spills occasionally occur on the docks.

7. The Charlotte terminal has 45 forklifts. The terminal operates three 10-hour shifts per day, with four (4) employees working the day shift; up to fifteen (15) employees the afternoon shift; and thirty (30) employees the night shift. All of these employees are forklift operators.

8. The Charlotte terminal is a less-than-truckload (LTL) facility. Drivers leave in the morning and make deliveries to local customers. They then pick up freight and return to the terminal. The trucks are usually full of freight when they return. Some of this freight is to be distributed locally. Freight which is to be shipped long distance is reloaded onto other trucks and sent to the next closest terminal where it is consolidated with other freight or reloaded onto another trailer. This process continues until the freight is delivered to the final customer.

9. When a truck returns to the terminal it is given a door assignment. The driver backs the truck's trailer up to the appropriate dock door. The driver then hands the paperwork to the dock office. The dock supervisor gets a load manifest and hands it to a dockworker and states where the trailer is located. The dockworker then drives a forklift to the door where the trailer is located and scans a bar code to see where within the terminal the shipment is to be delivered. The dockworker is then supposed to check to see if the trailer's wheels are chocked. He then lowers the dock plate and drives the forklift onto the trailer to begin unloading its freight. If available, the dockworker may load the freight directly onto another trailer or trailers located at one or more of the other dock doors. If part of the freight is to be loaded onto a trailer which is not currently at the terminal, the dockworker takes the load to a staging area to wait for the trailer to arrive. When the dockworker finishes one assignment, he or she will go to the dock office to get another manifest and begin the process over again.

10. Dockworkers operate the forklifts throughout the facility. When unloading freight, the operator drives the forklift forward onto the back of the trailer places its forks under a pallet containing freight picks the pallet up by raising the forks and backs out of the trailer. The operator then usually turns the forklift in one direction or the other and drives in a forward or backward motion in order to proceed down the dock (parallel with the dock's edge) to another trailer along the dock for loading. A forklift may have to travel some distance when traveling from one trailer to another along the dock. The forklifts may also be driven across the interior of the terminal for delivery to either a trailer located on the dock on the other side of the terminal building, or to an interior staging area.

11. During its busy time, thirty (30) of respondent's forklifts would be moving throughout the terminal at the same time. The dock is crowded when all thirty forklifts are moving. When going to and from the trailers, many of these forklifts would drive within the twenty (20) foot area between the dock's edge and the bay areas where freight is staged. In doing this, forklifts would often pass each other while traveling in opposite directions along the dock.

12. There are no markings on the pavement to show the operators where they are to drive and no physical barriers to keep them from operating in each other's "lane" to keep them from getting close to the dock's edge or to keep them from driving off the docks edge. Additionally, at the same time, other forklifts travel perpendicular to the dock's edge when coming from the dock on the other side of the terminal building or from an internal location such as a freight staging area. There are also no lines or other markings delineating crossing aisle ways or acting as stop signs. As a result, the paths of moving forklifts often cross. There have been occasions when it appeared as if forklifts were about to collide and an operator had to make an evasive action or movement to avoid a collision.

13. Respondent's forklifts also operate off-dock. Several of respondent's larger facilities have ramps which allow its forklifts to have access from the terminal to other buildings, such as the shop. At Charlotte, respondent has a concrete ramp at Dock 141 leading from the terminal to the parking lot. The ramp, which is approximately 30 feet long and 12 feet wide, is located outdoors and is not enclosed from the elements. The ramp does not have guardrails but has a 3" to 4" high curb with a rounded top.

14. The ramp is used on a daily basis by respondent's forklift operators to travel across the parking lot to a separate shop building located approximately one hundred (100) to one hundred and fifty (150) feet away. The operators would use a forklift to take materials or freight to the shop, such as a shipment of new brake shoes which would be used by the shop to repair trailers. The operators would also take freight or materials, such as used brake shoes, from the shop to the terminal for shipment. In traveling to the shop, the operators would descend the ramp with a load on the forklift forks, travel across an uneven parking lot, which at times would have pot holes, and enter the shop. On the return trip the forklift might ascend the ramp with a load.

15. The respondent has no rule, nor are there any limiting devices on the forklifts, to keep the operators from raising their loads to the maximum height when traveling on the ramp or across the parking lot.

16. In addition to the delivery of freight or material to and from the shop, a mechanic would occasionally use a forklift off dock when repairing dock boards. The forklift would be driven down the ramp located at Dock 141 onto the parking lot. It would then be driven along the parking lot until it reached a bay where dock board repair work was to be performed. At the time of the inspection at issue, a forklift was being used by one of respondent's mechanics to repair a dock board at Dock 182.

17. The forklifts used by respondent at its Charlotte facility are counterbalanced, center control, high-lift trucks with a sit down, non-elevating operator. Each forklift is equipped with a seat belt by the manufacturer . The respondent's forklifts have a maximum speed of 7 to 8 miles per hour. An operator usually travels at maximum speed when not carrying any freight or material. An operator may travel at a slower speed when carrying a load. The respondent has no written safety rules or regulations which tell an operator that they cannot exceed certain speeds when traveling loaded/unloaded, or are making turns.

18. The respondent does not have an enforced speed limit for forklifts. Its forklifts do not have governors or any other mechanical apparatus which will reduce the forklift's speed, especially when making a turn.

19. When a person applies for a dockworker position at respondent's Charlotte terminal, such applicant fills out an application and is given a drug screen test. The applicant is then given a copy of respondent's forklift training manual to read on his or her own, and then is given a written test. None of respondent's employees goes over the manual with the applicant to make sure that they understand what they are reading. If the applicant passes the written test, he or she is given a driving test which is supervised by another dockworker who has not been trained as a trainer. If that dockworker is satisfied that the applicant has passed the driving test, he observes the applicant for a short period of time to determine if the applicant properly picks up and moves freight. Applicants are given no other safety training. Further, they are not instructed or tested on respondent's General Safety Training Manual. Additionally, neither new nor experienced operators are provided, or have available to them for review a copy of the operator's manual for Central's forklifts.

20. Gary Burkholder is employed in the corporate training department of Barloworld Handling. Barloworld is a world wide distributor of lift trucks, primarily Hyster forklift trucks, and is the largest Hyster dealer in the United States. It does business in eleven states in the southeast, including North Carolina. Barloworld's corporate headquarters are located in Charlotte, North Carolina.

21. Barloworld's corporate training department provides training to its employees on the safe operation of lift trucks. It also provides forklift operation and safety training to its customer's lift truck operators, including training forklift operator trainers. This includes training on the stability of forklift trucks, the hazards associated with operating forklifts, including safety issues in terms of tip-over and driving off loading docks; the safety devices available to protect forklift operators from injury; and the required safety practices for the operation of a forklift.

22. Mr. Burkholder is the senior trainer in Barloworld's corporate training department. Mr. Burkholder is the trainer who primarily conducts "train the trainer training" This includes training other forklift operator trainers on the operation and safety of sit-down, rider, counterbalanced, high-lift, forklift trucks. He has participated in numerous conferences and seminars as a presenter on forklift training, including operation and safety. He also participated in the public hearings which culminated in the 1999 amendment of °1910.178(l), the OSHA forklift training standard.

23. Mr. Burkholder has been a forklift operation and safety trainer with Barloworld for twenty-eight years. Prior to that he was a road service technician and branch trainer for Barloworld in Charleston, South Carolina. Prior to his employment with Barloworld, Mr. Burkholder worked for a little over four years with a Caterpillar lift truck dealership. As a result of his years of experience, Mr. Burkholder has become familiar with, and has provided training regarding, the operation and business of loading and unloading materials, such as palleted freight from tractor-trailer trucks by use of forklifts. In addition to his practical and training experience, as part of his job responsibilities Mr. Burkholder reviews applicable forklift standards, federal OSHA standards interpretations, forklift accident reports, lift truck operator manuals, and forklift accident studies. Following a voir dire, Gary Burkholder was admitted as an expert witness in the field of forklift operation, training and safety. Previously, he had testified as an expert in a civil case in the field of forklift stability and safety.

24. According to federal OSHA statistics, a forklift tipping over and catching the operator between the overhead guard and the ground is the primary cause of forklift operation fatalities. Another leading cause of death occurs when a forklift goes off-dock and falls on an operator who attempted to jump or has fallen out of the forklift.

25. Mr. Burkholder testified extensively regarding the stability of forklifts trucks (especially when empty), including the hazard of possible tip-over and off-dock incident. He illustrated his testimony with a model demonstration showing how tip-overs may occur. He also used a power point demonstration, including slides of forklift turnovers, to demonstrate the possibility of a forklift tip-over even on a smooth, level, concrete surface such as is found on a loading dock. He also testified to the hazards of operating a forklift on a ramp or inclined surface. Mr. Burkholder also referred to sections of Barloworld's Instructor's Guide regarding forklift stability and possible tip-over. Mr. Burkholder uses this guide when providing forklift operation and safety training.

26. Mr. Burkholder further testified that the overturn of a forklift is a recognized hazard. Approximately twenty-five percent (25%) of all forklift related fatalities and serious injuries resulted from lateral tip-overs. When a tip-over occurs, it is likely that the operator's head will be caught between the overhead guard and the ground if the operator does not remain within the forklift. Mr. Burkholder also testified that it is a recognized hazard that forklifts will go off-dock. It is a recognized hazard that tractor trailers may move away from the loading dock as a forklift is either entering or leaving the trailer, resulting in the lift truck dropping in between the tractor trailer and loading dock. Additionally, it is a recognized hazard that a forklift may go off-dock due to trailer creep caused by, for example, a trailer moving away from the dock as a forklift enters due to faulty brakes and/or the trailer's wheels not being properly chocked. It is also a recognized hazard that a forklift may simply drive off-dock for any number of reasons, including slippery floors and operator error.

27. Based upon his understanding of respondent's operations at its Charlotte facility obtained from his conversations with the compliance officer; his review of the photographs of respondent's Charlotte facility and his general understanding of the industry, Mr. Burkholder testified that he is familiar with the conditions and hazards which exist at respondent's Charlotte facility as it relates to the operation of forklifts. In his expert opinion, there is a possibility that a forklift operating in the areas shown in the complainant's photographs could tip over.

28. Conditions at respondent's Charlotte terminal which could exacerbate the possibility of tip-over include cracks in the floors; the monorail on the floor, which is bent up in one area; the ramp, the parking lot, and wet floors. These conditions, however, do not need to be present for a tip-over to occur. Based upon Mr. Burkholder's experience, a tip-over can occur on a smooth, flat floor such as found at a trucking terminal, warehouse, or parking lot.

29. There is also the possibility that a forklift could go off-dock at respondent's Charlotte facility, either as a result of the operator driving it off the dock without a trailer present, or as a result of a trailer pulling or creeping away from the dock as a forklift was entering or leaving the trailer.

30. Mr. Burkholder testified that in 1993 the American Society of Mechanical Engineers (ASME) amended B56.1, its safety standard for forklifts, to include requirements for the protection of forklift operators in case of tip-over or off-dock incident. Both the American Trucking Association and Industrial Truck Association served on the rules committee which adopted this requirement. This requirement provides, in pertinent part, as follows:

> 5 OPERATING SAFETY RULES AND PRACTICES
>
> 5.1 Operator Responsibility
>
> 5.1.4 Before operating any truck, truck operators shall have read and be familiar with the operator's manual for the particular truck being operated and they shall also abide by the safety rules and practices in paras. 5.2 through 5.5

ASME B56.1 also provides:

> 5.3.19 An active operator protection device or system, when provided, shall be used. Operator protection in the event of tipover is intended to reduce the risk of entrapment of the head and torso between the truck and the ground . . . . However, steps indicated in paras. 5.3.18(d) and (e) should still be adhered to.

Paragraph 5.3.18 of ASME B56.1-1993 provides:

> (d) The operator should stay with the truck if lateral or longitudinal tipover occurs. The operator should hold on firmly and lean away from the point of impact.
>
> (e) The operator should stay with the truck if it falls off a loading dock or ramp. The operator should hold on firmly and lean away from the point of impact.

Paragraph 7.39 of ASME B56.1-1993, entitled Operator Restraint Systems, provides:

> (a) Counterbalanced . . . lift trucks . . . shall have a restraint device, system, or enclosure that is intended to assist the operator in reducing the risk of entrapment of the operator's head and/or torso between the truck and ground in the event of a tipover. . . .
>
> (b) Warnings and instructions on the purpose and use of the operator protection provided shall be displayed in clear view on the truck and included in the operator's manual.

31. Based upon this standard, both the American Trucking Association and the Industrial Truck Association recognize the hazard of possible tip-over or off-dock incident, and recommend that forklift operators use the provided operator restraint device. This further shows that both of these associations also recognize that an operator might be caught between the forklift and ground if he or she does not remain with the forklift, and that the use of an operator restraint device might prevent death or serious bodily injury, or would significantly reduce the seriousness on an injury, in case of tip-over or off-dock incident.

32. Mr. Burkholder explained that an operator protection device is required to be used any time that a counterbalanced, center control, high lift truck with overhead protection and a sit-down, nonelevating operator is being operated. The respondent's forklifts are of this type.

33. Further, the operator restraint device must have an "active" component, a seat belt. The operator protective device installed on respondent's forklifts by the manufacturer, Toyota, consists of a winged seat, a seat belt, and warning labels advising the operator to "buckle up" and, in case of tip-over, to hold onto the steering wheel, brace the feet, and lean away from the direction of tip over. According to Mr. Burkholder, the provided seat belt is an integral part of the operator restraint device on respondent's forklifts and must be used.

34. Mr. Burkholder read, in pertinent part, from the Preamble to the 1999 amendment to §1910.178(l), the OSHA training standard, which concluded, as follows:

> III. Powered Industrial Truck Hazard
>
> . . . .
>
> [O]perators of sit-down rider trucks are often injured in tip-over accidents when they attempt to jump clear of the vehicle as it tips over. Because the operator's natural tendency is to jump downward, he or she lands on the floor or ground and is then crushed by the vehicle's overhead guard; therefore, operators of sit-down trucks need to be trained to remain in the operator's position in a tip-over accident and lean away from the direction of the fall to minimize the potential for injury.

. . . .

Mr. Burkholder further read from the Preamble:

> Driving a powered industrial truck at excessive speed can result in a loss of control causing the vehicle to skid and tip-over or fall off the loading dock or other elevated walking or working surfaces. This condition can be made more dangerous because the load being carried sometimes partially obscures the operator's vision.

35. Gary Burkholder also referred to Section IV of the preamble containing a statistical analysis of forklift accidents and injuries, including injuries from tip-overs and off dock incidents. According to one analysis of 170 powered industrial truck fatalities, twenty-four percent (24%) of the fatalities resulted from forklift tip-overs. This was the highest percentage of fatalities in the study. Eight percent (8%) were the result of off-dock incidents. Therefore, thirty-two percent (32%) of the forklift related fatalities studied resulted from tip-overs and off-dock accidents. Another study contained in the preamble showed that twelve point three percent (12.3%) of the lift truck operator injuries involving lost workday claims which occurred in 1991-92 were in the trucking industry. These statistics clearly show that a leading cause of forklift operator fatalities and other serious injuries in the trucking industry is forklift overturns and off-dock incidents.

36. Mr. Burkholder testified that §1910.178(l) (1999) requires that operators be instructed on the following:

> (3) Training Program Content. Powered industrial truck operators shall receive initial training in the following topics. . .
>
> (i) Truck-related topics:
>
> (A) Operating instructions, warnings, and precautions for the type of truck the operator will be authorized to operate;
>
> . . .
>
> (I) Vehicle stability;
>
> . . . .
>
> (M) Any other operating instructions, warnings, or precautions listed in the operator's manual for the types of vehicle that the employee is being trained to operate;

37. According to Mr. Burkholder, °1910.178(l) specifically requires respondent to train its new operators on the operator instructions and warnings contained in its Toyota forklift operator's manual, including on the hazards of possible tip-over, as well as on the instructions and warnings relating to the use of the described operator protective device, including the seat belts.

38. Seat belts assist the operator in remaining in the forklift's seat in case of a lateral tip-over or off-dock incident. This allows the operator to use his or her upper body strength to maintain the rest of his or her torso and head inside the confines of the overhead guard. If not buckled up, the operator will probably not be able to keep himself or herself from coming off the seat and being struck by the overhead guard or other part of the truck. This could result in death or serious bodily injury. A seat belt will help keep an operator in his or her seat whether the forklift has a winged seat, or a seat with a hip restraint. Seat belts also assist the operator in avoiding serious injury in the case of a longitudinal tip-over.

39. An operator should not attempt to leave or jump clear of a tipping forklift. Tests conducted by Mr. Burkholder showed that it is very difficult to impossible for an operator to get far enough away from the truck to avoid being struck by the overhead guard. This is confirmed by the significant number of fatalities which have occurred as the result of operators who failed to accomplish such an ill-fated attempt. If an operator were to feel that a forklift were beginning to tip-over or go off-dock, the natural tendency would be to attempt to exit on the low side - the side to which the forklift was falling. This would put the operator in harms way of the overhead guard. To exit from the high side, the operator would have to go up hill and, as a result of the cabin floor tilting away from the operator, it would be difficult for the operator to sufficiently plant his or her feet in order to successfully make such a move.

40. The operator might not correctly guess which way the forklift will fall, especially in an off-dock incident. Jumping clear presents other hazards, such as being struck by another forklift, falling off the dock, being struck by the freight, or, in case the forklift does not turn over, being struck by his or her own forklift.

41. It constitutes a greater hazard for a forklift operator to jump from an overturning forklift, or one going off-dock, than to remain with the truck. This is especially true when the operator is wearing a seat belt. It would constitute a greater hazard at respondent's Charlotte facility for its employees to jump off rather than to stay with a forklift in case of tip-over or an off-dock incident.

42. A study conducted by Hyster from 1983-86 concluded that the use of seat belts as part of an operator restraint system would significantly lower injuries in forklift overturn accidents, including off dock incidents. The purpose of the study was to decide upon the types of operator restraint system to use. According to this study, lateral and off-dock accidents produce the most serious injury. It found that operators who receive major injuries usually are attempting to jump clear prior to the truck's impact. The study further found that a properly installed seat belt is effective in controlling the force of the lower-body torso in keeping the operator in the seat. If seating can be maintained, most operators have adequate arm strength to control the initial inertia forces of the upper torso at the truck impact, so that the so-called "fly swatter" effect is manageable. The Hyster study concluded that the two most effective devices in preventing serious injuries in case of tip-over or an off-dock incident are a seat belt and hip restraint. "the seat belt is the primary means and most effective of the two."

The Hyster study further concluded:

> The operator restraint system consists of seat belt with the belt retractor, hip restraint brackets with latches, hardware, and instruction warning decals. . . .
>
> . . . .
>
> The results showed that the operator restraint system is effective. At impact, the velocity data indicated the low probability of serious injury. . . [a]nd there was no entrapment under the truck.
>
> . . . .

The Hyster study additionally determined:

> Tests were done to evaluate the operator restraint system in tip-overs at loading docks. Off-dock tip-overs are severe . . . . The operator's area remained intact throughout the dock related tests. If the operator remains with the truck by wearing the seat belt, the potential for avoiding serious injury appears to be good relative to other choices. . . .

Hyster's 1983-86 study further determined that the time that it takes to jump to a standing position from an overturning forklift exceeds the time that it takes for the forklift to go from the balance point to impact. In other words, an operator cannot get out of the way quickly enough. This is true for forklifts that are turning over and going off-dock.

The study finally concluded:

> Further tests show that the operator restraint system does not significantly affect either the exist time in non-tip-over conditions or visibility.

Hyster conducted a five year follow-up study from 1986 to 1991 of reported incidents involving Hyster forklifts which were involved in side tip-overs, nose overs, and over the dock incidents. Eighty-one (81) of these incidents involved forklifts which were not equipped with an operator protective device. Seventy-seven (77) involved forklifts which had operator protective devices. Of the eighty-one (81) incidents without an operator protective device, twenty-nine (29) were off-dock and fifty-two (52) were lateral tip-overs. Approximately fifty-three percent (53%) of the operators of these forklifts were killed or seriously injured as they jumped or were thrown from the trucks. Of the seventy-seven (77) instances involving forklifts equipped with an operator restraint device, twenty-seven (27) involved an off-dock incident and fifty (50) a lateral tip-over. Only seventeen percent (17%) of these incidents resulted in a serious injury. Hyster conducted a further five year follow-up study and noted that the results, after the ten year period, were still very favorable for the use of an operator restraint system. The study further concluded that no serious injury has occurred to a driver who was wearing the seat belt component of the system.

43. The respondent's Toyota forklifts were outfitted by the manufacturer with an operator protective device or system including a seat with wings, a seat belt, and warning labels. The Toyota operator's manual for respondent's forklifts repeatedly warns and instructs the operator with written text and illustrations that "restraints must be used to reduce the possibility of injury from overturns or other accidents" The Toyota operations manual shows that the provided seat belt is an integral part of the operator protective device. The manual contains numerous warnings and instructions to operators to fasten their seat belt. The manual additionally repeatedly discusses the hazards of tip-over, and of hazards around the dock, including off-dock incidents and how they may occur. For instance, the manual specifically advises:

> WARNING: Buckle up. Your seat belt can reduce the risk of serious injury or death in the case of truck turnover. Your chances of avoiding serious injury or death in a tip-over are better if you stay with the truck in the operator's compartment.
>
> . . . .
>
> Always wear your seat belt when driving the truck. The truck can tip over if operated improperly. To protect the operator from the risk of serious injury or death in the event of a tip-over, it is best to be held securely to the seat. The seat and seat belt will help to keep you safe within the truck and operator's compartment in the event of a tip-over. Don't jump. Grip the steering wheel, brace your feet, lean away from the direction of impact, and stay with the truck.

44. Pursuant to § 1910.178(l)(3)(M), the respondent is required to instruct its operators on these instructions, warnings and precautions. These same type warnings and instructions are contained in other forklift manufacturer's operating manuals, such as Hyster's.

45. It is very easy for a forklift operator to use a seat belt. This is especially true where retractable belts are provided. Retractable belts are consistently available to be pulled out to the right length and retracted. It takes at most two (2) seconds to buckle up, and about a half (1/2) second to unbuckle a seat belt. A study showed that requiring operators to use seat belts does not adversely affect their production. For instance, the study shows that operators who were required to get on and off a forklift hundreds of times a day would spend only about five minutes of the day buckling and unbuckling their seat belt.

46. Other tests have shown that the use of a seat belt would not perceptively interfere with an operator's ability to quickly exit a forklift in an emergency situation, such as where a load of freight or materials falls into the side of the cab.

47. The use of a seat belt does not interfere with the operation of a forklift, including operating it in backwards mode.

48. There exist several federal OSHA letters of standards interpretation in its training manual relating to the required use of seat belts on forklifts and OSHA enforcement. For instance, on March 7, 1996, the Director of the Directorate of OSHA Compliance advised that, if seat belts are installed on lift trucks, it is required that the belts be worn. He further advised that OSHA would enforce this requirement under the provisions of section 5(a)(1) of the OSHA Act, the general duty clause. In a letter dated May 22, 1998, the Director further advised that, even though seat belts are not specifically mentioned, they must be worn if supplied as a part of the operator protective device or system. He further advised that "OSHA has not made any exclusions regarding the use of operator restraint systems" Additionally, in a letter dated May 28, 1997, to the president of the ATA, the Director refers to an earlier October 9, 1996, Memorandum to Regional Administrators regarding the use of seat belts on powered industrial trucks. In that Memorandum, it is stated:

> OSHA's enforcement policy relative to the use of seat belts on powered industrial trucks is that employers are obligated to require operators of powered industrial trucks which are equipped with operator restraints, devices, or seat belts to use the devices. OSHA would enforce the use of such devices under Section 5(a)(1) of the OSH Act.

49. The respondent has published its own Forklift Truck Training Manual. The respondent includes in its manual the following warning:

> Side tip-overs can be prevented. If your truck begins to tip sideways, whatever you do, stay in the truck, hold tight, brace your feet, lean away from the direction of the tip, never try to jump. There is not enough time for you to get clear of the lift truck.

50. The manual also shows an illustration of a decal on an overhead guard advising employees to hold tight, brace their feet, and lean away in case of tip-over. These are the same type warning labels Toyota has placed on respondent's forklifts as part of its operator protective device, except that respondent's manual does not include the label advising operators to buckle up.

51. Mr. Burkholder testified that §1910.178(k)(1) provides that the rear wheels of trailers must be chocked and brakes set to prevent rolling while they are being boarded by forklifts. A chock is a device placed in front of the tires to prevent the trailer from rolling. Typically, they are rubber or aluminum, and are designed to fit the contour of the wheel. A 4" x 4" board would not constitute a wheel chock. Chocks are required to be in front of the rear wheels on both sides of the trailer. Mr. Burkholder's review of the photographs taken by the compliance officer show that the wheels of some of respondent's trailers were not chocked. They further show that a restraint system was not being used to secure the trailer to the dock. The wheels, therefore, were required to be chocked. The respondent's failure to chock the wheels presented a hazard to respondent's employees - the trailer could creep away from the dock as forklifts were entering, leaving a gap which a forklift could fall into, resulting in an off-dock/off trailer incident. Both the forklift operator's manual and respondent's own safety manual require that the wheels of trailers be chocked.

52. If two forklifts were to collide, it would be a greater hazard for the operators to jump off than to remain with the forklifts. AMSE B56.1-1993 requires an operator to wear a seat belt if provided. Further, the standard makes no exception to this rule. The standard recognizes that it is safer to stay with the forklift than to leave the truck in the case of a tip-over or off-dock incident. This is further recognized by the forklift and trucking industries.

53. There are numerous articles and studies concerning forklift operation. This includes the hazards associated with operating forklifts, including the hazards of tip-over and off-dock/off-truck incidents. There is a consensus among these articles and studies that forklifts will tip over or fall off docks. Further, there is a consensus that, if such an incident were to occur, it is best to stay with the forklift and that, if provided, seat belts should be used.

54. The respondent has approximately thirty-two Toyota forklifts in use in its Charlotte terminal. Each of the forklifts has an operator protection device or system consisting of an overhead guard, winged seat, seat belt, and warning labels. The seat belt was an integral part of the operator safety device. The purpose of the seat belt is to keep the operator from falling or being thrown out in case of tip-over or an off-dock incident. It also keeps the operator from being thrown into the mast or uprights to the overhead guard in case of a frontal collision or off-dock incident.

55. The respondent's forklifts contain several labels, including warning labels, on the overhead guard. One label references the ANSI/ASME B56.1 standard. Another label consists of a series of blocks or illustrations with different warnings. Starting from the left, the first block states "WARNING". The next block has a picture of an operator in a forklift attaching his seat belt and says, "Seatbelts help reduce tip-over injury if you follow these instructions". The next block shows a copy of the operator's manual, thereby advising the operator to read it. Next to that it says "DANGER". The next block shows an illustration of tipping forklift and says, "Don't jump" advising the operator not to jump out of the forklift in case of tip-over. The final three blocks say "hold on tight" (to the steering wheel), "brace feet" and showing a tipping forklift, "lean away" (from the direction of the fall). The purpose of these labels is to be a continuing reminder to the operator of the hazards and dangers of driving a forklift and the steps to be taken to avoid injury.

56. None of respondent's employees wear seat belts while operating forklifts as it is not required by the respondent.

57. The edge of the loading dock where respondent's trailers are pulled up to is four feet (4') high and is open sided. There are no doors, guardrails or other barriers or devices to keep the forklifts from getting near or at the edge of the dock when a trailer is not at a dock door.

58. An operator could simply drive off the dock and receive an injury or injury could occur due to trailer drift. This can be caused by the force and weight of a forklift entering a trailer, causing the trailer to move forward and away from the dock, creating a space into which a forklift could fall. Another possible incident could occur if a driver pulls the trailer away from the dock while a forklift is either entering the trailer, or is inside backing out. Such an incident occurred on May 16, 2005 at respondent's facility in Duncan, South Carolina, resulting in the death of the forklift operator who was not wearing his seat belt.

59. There is a natural inclination for an operator to attempt to jump from a forklift which is tipping over or going off-dock. Additionally, an operator not wearing a seat belt could be thrown from the forklift as it tips over. In either case, the likely scenario would be for the operator to be caught between the overhead guard and ground, resulting in death or serious bodily injury. Additionally, without a seat belt, the operator could be thrown forward into the steering wheel or mast. A seat belt would help keep and stabilize the operator in the seat and prevent or substantially reduce the possibility of death or a serious injury. The use of a seat belt could also prevent or substantially reduce the possibility of death or serious bodily injury in an off-dock incident. If a forklift were to go off-dock while an operator was not wearing a seat belt he or she could fall out or jump to the ground below, only to have the forklift or overhead guard fall on her or him. A seat belt would assist the operator to remain within the confines of the cab and overhead guard, substantially increasing the likelihood of avoiding death or a serious bodily injury.

60. It is possible for an operator to receive an injury in a tip-over or off-dock incident even if wearing a seat belt. The use of a seat belt greatly reduces the severity of injury or likely death which would likely occur without its use. It would be a greater hazard for the operator to be unbuckled than buckled up as a forklift tips over. It would also be a greater hazard for the operator to be unbuckled than buckled up in an off-dock situation.

61. Effective November 30, 2000, federal OSHA issued Directive CPL 2-1.28A regarding the powered industrial truck operator training standard, °1910.178(l). This instruction provides compliance and assistance for ensuring a uniform enforcement of the standard. Within this Directive, OSHA states:

> Seatbelts on forklift trucks are a component part of the operator restraint system that is designed to reduce the incidents and severity of injuries to the operator in the event of a tip-over accident. Forklift trucks are particularly susceptible to tip-overs. Failure to wear the seat belt that is provided in the forklift increases the risk of injury to the operator in the event of such an accident. Section 1910.178 does not currently contain requirements for the use of operator restraint systems. However, Section 5(a) (1) of the OSHA Act requires employers to protect employees from recognized hazards. Recognition of the hazard of forklift tip-over and the need for operators to use an operator restraint system is evidenced by certain requirements in the more current version of ANSI B56.1 consensus standard for powered industrial trucks and ASME B56.1-2000 safety standard for low-lift trucks. In addition, seatbelts have been supplied by many manufacturers of the counterbalanced, center control and high-lift trucks that have a sit-down, non-elevating operator position. OSHA'S enforcement policy on the use of seatbelts on powered industrial trucks is that employers are obligated to require operators of powered industrial trucks that are equipped with operator restraint devices including seatbelts to use the devices. OSHA will enforce the use of such devices under Section 5(a)-1 of the OSHA Act in accordance with the October 9, 1996, seatbelt enforcement memorandum.

62. North Carolina OSHA has adopted this Directive. This Directive shows that both federal and North Carolina OSHA recognize that forklifts are particularly susceptible to tip-over; that an operator restraint system can prevent death or serious bodily injury; that, when provided, seat belts are an integral part of an operator safety device; and, that employers are obligated to require operators of forklifts equipped with seat belts to wear them.

63. In June 2001, the National Institute for Occupational Safety and Health (NIOSH), an agency with the Center for Disease Control of the U.S. Department of Health and Human Services issued a NIOSH Alert regarding preventing injuries and deaths of workers who operate or go near forklifts. According to the alert, approximately 20,000 people are injured in forklift accidents each year. Approximately 100 of these are killed each year. Most of these fatalities occur when a worker is crushed by a forklift that has overturned or fallen off a dock. Overturns is the leading cause of fatalities involving forklifts. Approximately twenty-five percent (25%) of all forklift related deaths that occurred from 1990 to 1994 resulted from forklift overturns. NIOSH warns and advises forklift operators to wear their seat belt if available, and not to jump from an overturning sit-down forklift but stay with the truck, hold on firmly, and lean in the opposite direction of the overturn. NIOSH concludes in its alert that many of the fatalities due to forklift tip-over might have been prevented if the operator had been restrained; that the overhead guard is generally the part that crushes the operator's head and torso; and, the risk of being crushed by the overhead guard or another rigid part of the forklift is greatly reduced if the operator remains inside the operator's compartment. The alert then advises again that operators should wear seat belts.

64. Pursuant to its Fatality Assessment and Control Evaluation program (FACE), NIOSH investigates certain accidents in order to formulate prevention strategies to avoid such accidents. Six (6) NIOSH FACE reports involving investigations into forklift tip-over fatality accidents were introduced. In each fatality, the operator, who was not wearing a seat belt, either jumped or was thrown from the forklift and was struck by the overhead guard or other part of the forklift. The conclusion reached by NIOSH in each case concerning how the deaths could have been avoided was to have required the use of seat belts.

65. The respondent could have abated the hazard presented to forklift operators at its Charlotte terminal by complying with the Toyota operator's manual and simply requiring the operators to wear the supplied seat belts.

66. Rule 1910.178(k)(1) requires that the brakes of highway trucks be set and wheel chocks placed under the rear wheels to prevent the trucks from rolling while they are boarded by forklifts.

67. The respondent has a policy requiring that the wheel of its trailers be chocked. Pursuant to this policy, the driver is supposed to back the tractor trailer (highway truck) up to the dock, set the tractor's brakes, chock the rear wheels of the trailer, and pull away the tractor.

68. The purpose of a wheel chock is to prevent trailer movement or trailer creep as they are being loaded and unloaded with forklifts. Failure to properly chock the wheels could result in trailer creep or movement, which could further result in a forklift that was either entering or exiting the trailer to drop between the trailer and dock to the ground below. If the operator is not wearing a seat belt, he or she could fall or attempt to jump out of the forklift and be crushed between its overhead guard or other hard structure and the ground, and be killed or seriously injured.

69. On March 4, 1998, federal OSHA issued a standards interpretation and compliance letter regarding §1910.178(k)(1). The inquiry and response are stated, as follows:

. . . .

> In your letter you discussed incidents where workers have experienced injuries when powered industrial trucks exited truck trailers on dock boards and the truck suddenly pulls away. Consequently, the dock board is displaced and the powered industrial truck falls to a different elevation causing serious injury to the worker.
>
> Trailer creep and trailer pull-away have long been recognized as a problem in dock operations. . . . If restraint systems are not used, trailers must be properly chocked to prevent movement as required in OSHA standards 29 CFR 1910.178(k)(1) and 29 CFR 1910.178(m)(7) . . . .

70. On March 28, 2003, North Carolina OSHA issued Standard Notice 66 relating to trailer wheel chocking. In this notice it authorized the use of a spring brake system in lieu of wheel chocking. Such permission, however, is contingent upon the employer's routine and unfailing implementation of a corporate policy of periodic maintenance, frequent inspection, and functional checking of the spring brakes prior to each trip to include when parking at the loading dock to ensure effectiveness and reliability. It further contains requirements which must be included in a written policy. Some of respondent's trailers had spring brakes. During his inspection, however, CSO Elgin found and determined that respondent had no written spring brake program and that it was not complying with all of the steps required in Standard Notice 66 to be exempt from the requirements of §1910.178(k)(1) to chock the wheels of its trailers.

71. Randy Miller is the terminal manager of respondent's Charlotte facility. He has been manager of the Charlotte terminal for ten years. Prior to that he was assistant terminal manager for two (2) years in Dayton, Ohio. He has also previously worked for the respondent as a sales representative, dock supervisor, and as a dockworker and switcher.

72. Mr. Miller testified that if a forklift makes a turn at a speed faster than two (2) miles per hour the load is going to fall off the skid. He then acknowledged that employees have turned too fast and freight has fallen. Despite this, he admitted that he enforces no speed limit at the Charlotte facility and no governor or other mechanical device has been utilized to assure that the operators do not drive too fast.

73. Two forklifts have been driven off the dock since Mr. Miller became terminal manager in Charlotte. In one case the operator drove the forklift backwards off the dock, resulting in a chipped tooth and a contusion. In the other instance no one was hurt. The forklift did not tip over in either instance and the operator remained in the forklift. According to Mr. Miller, no forklift has driven off the back of a trailer at Charlotte since he became terminal manager.

74. Mr. Miller testified that he was unaware as to whether respondent has conducted any assessment of the risks posed by forklift operations. When asked on direct as to what risks he thinks are associated with operating a forklift, he stated: (1) striking a pedestrian and (2) someone pulling the wrong trailer by mistake as a forklift operator was attempting to load or unload a trailer.

75. Although seatbelts are provided by the manufacturer on respondent's forklifts at the Charlotte facility, the forklift operators are not trained to use the seatbelts.

76. The respondent does not have a Toyota Operators Manual for its Toyota forklifts at the Charlotte facility.

77. Tara Murphy is head of corporate safety for respondent. She has been in this position for seven (7) months. Previously, she had been in respondent's safety department since 1996. As part of her duties with the safety department, Ms. Murphy is responsible for the overall safety of 165 terminals in the United States and Canada. As part of her duties with the safety department since 1996, her responsibilities have included OSHA inspections and visiting respondent's facilities. However, Ms. Murphy has not visited respondent's Charlotte terminal.

78. The respondent is a member of the Michigan Trucking Association, which is affiliated with the American Trucking Association (ATA). The ATA handles all areas of trucking, including LTL freight. The ATA is largely a lobbying group. The ATA also has experts in the regulatory realm and will take positions on various issues.

79. The respondent operates in forty-two (42) states. OSHA has inspected facilities in approximately twenty (20) states. As a result, the respondent was cited by South Carolina OSHA for failure to require its employees to wear seat belts. This citation resulted from an incident in which an employee was killed when he tried to leave the forklift as it went off the back of a trailer which was being pulled away from the dock. Ms. Murphy could not recall any other instance in which respondent had been cited.

80. Ms. Murphy testified that respondent has conducted an assessment of the risks to which its forklift operators are exposed. This includes assessing by regulatory research. In doing an assessment she would look at multiple government websites. Part of Ms. Murphy's job is to keep up with changing regulatory and industry standards. Another part of respondent's assessment involves looking at its own accident investigation and injury and illness records. Additionally, Ms. Murphy will call terminals and talk with the dock supervisor. She also talks with the dock workers. Ms. Murphy also stated that as part of the assessment process she reviewed a study showing that seat belts make forklift operators less safe.

81. According to Ms. Murphy, approximately ten (10) to twenty (20) forklifts go off dock each year at respondent's facilities. The respondent has not experienced a forklift tipping over on the dock. The respondent does not prohibit its employees from wearing seatbelts. Due to its having a higher rate of injuries when high-lows are ridden down, respondent recommends that the operator of a high-low forklift jump off if it goes off dock. According to Ms. Murphy, she considers it a greater hazard to remain with a falling forklift and recommends that a driver attempt to jump despite the fatality which occurred in South Carolina.

82. Ms. Murphy does not believe that it would be difficult to enforce a seat belt policy, and knows of no reason why respondent could not enforce one. Further, the cost of implementing such a safety procedure or safety mechanism would not prevent respondent from implementing it.

83. The respondent has a policy at its Charlotte facility requiring the use of wheel chocks. When a trailer is backed up to the dock for purposes of unloading/loading, the switcher or driver is supposed to place wheel chocks under both sets of rear wheels. Instead of using standard wheel chocks, respondent uses 4' x 4' lumber. The chocks are to remain in place until the trailer is ready to be pulled. After removing the chocks the trailer pulls off. The respondent has previously been cited for failure to place wheel chocks at the wheels of its trailers.

84. Ms. Murphy testified on cross-examination that less than one percent (1%) of its forklift operators wear seatbelts. In most cases when a forklift went off dock at respondent's facilities, the operator was not wearing a seat belt. Further, while she earlier testified that respondent's incident reports indicate a higher rate of injuries among operators who remained with the forklift going off dock as opposed to those who did not, she did not determine whether any of the operators staying with the truck were wearing seat belts. Additionally, she stated that respondent could not have done a study of what kind of injury has occurred to operators wearing a seat belt versus operators not wearing seat belts because it did not have the data necessary to conduct such a comparison. Ms. Murphy was not aware of any incident where an operator wearing a seat belt was thrown from the forklift and was caught between the overhead guard and the ground. Finally, Ms. Murphy has not observed any videos, and has not attempted to otherwise determine whether employees can jump from a falling forklift in time to avoid death or serious physical harm.

85. Ms. Murphy testified that she has reviewed studies relating to the incidents of forklifts overturning on ramps. Although she stated that they have not had any such incidents during her experience with respondent, the studies show that a forklift operating on a ramp, especially if a turn occurs, has a higher potential for tip over. She also agreed that tip-overs occur to forklifts while driving across parking lots.

86. Ms. Murphy became familiar with ASME B56.1 as part of her involvement in respondent's hazard assessment, including the 1993 amendment. Ms Murphy admitted that, as a result, she is aware that ASME B56.1-1993 requires that an active operator protective device shall be provided and used on respondent's forklifts. She further admitted that she was aware that the standard states that the device is intended to reduce the risk of entrapment in case of tip-over, and that there must be an active component of that device. Additionally, she admitted that the forklifts at respondent's Charlotte facility were equipped by the manufacturer with an operator protective device, including seat belts, and that these seat belts were an integral part of the device. Ms. Murphy was unaware of any study saying that an employer may ignore the use of an active operator protection device. Ms. Murphy is also familiar with the part of ASME B56.1-1993 which instructs that an employee should not attempt to jump but stay with a forklift in case of tip over or off dock incident. The instruction provides that an employee should plant his or her feet, grab the steering wheel, and lean away from the direction of tip over or fall.

87. Ms. Murphy was familiar with the §1910.178(l) training standard as amended in 1999. However, although part of her job responsibilities is to become familiar with applicable OSHA standards, she was only partially familiar with the preamble to the standard. For instance, although she recalled that the preamble concluded from the studies reviewed that the leading cause of forklift fatalities was due to tip-over, she could not recall that it also concluded that studies showed that off dock incidents was another leading cause of death. Further, even though she could recall that the preamble further concluded that an operator is often crushed when he or she attempts to jump from an overturning forklift, she could not recall it recommending that the operator stay with the forklift.

88. Ms. Murphy was not familiar with the study done by Hyster in which it determined that the use of seatbelts as part of an operator restraint device would save lives in case of a tip-over or off dock incident. She was, however, familiar with the Toyota Operator's Manual for the type of forklift used at respondent's Charlotte facility and that it discusses the risk of tip-over associated with operating forklifts, as well as states that the supplied seat belt is a part of the operator protective device. While she believes that the manual also instructs the operator to wear the seat belt when operating a forklift, she could not remember whether it does so instruct. Ms. Murphy was also familiar with the fact that respondent's own forklift operator's training manual specifically warns of the hazard of possible tip-over, and that it instructs the operator to hold on, lean forward, and stay with the forklift in case of tip-over.

89. Ms. Murphy admitted that, although respondent's assessment of the hazards associated with operating forklifts is a continual process, she was not aware of the NIOSH Alert warning of the hazard of forklift tip-over and advising that it was the leading cause of death of forklift operators. She also could not recall any specific study, article or treatise relied upon by respondent in conducting its hazard assessment.

90. Ms. Murphy admitted that a seat belt would prevent an operator from being propelled into the mast of a forklift in the case of a straight off-dock incident. She also conceded that a forklift will sometimes tip or turn over when going off dock. In fact, this has occurred at respondent's facilities. She also admitted that there was no way the operator could predict which way it might fall, and that there is the possibility it could strike an operator who either fell or jumped from the forklift. Ms. Murphy further conceded that she has read studies which conclude that the most important factor in preventing serious injuries is to protect the operator from being struck by the overhead guard in case of tip-over or off-dock incident. She also admitted that, in case of a tip-over, it is best for the operator to remain in the forklift.

91. Ms. Murphy stated that she could not provide any example where an operator using a seatbelt was injured where he or she would not have been injured if not wearing the seat belt. She also stated that she did not have any study or report with her that shows the hazard analysis which she purportedly conducted concerning forklift operations. She could not cite any publication from the trucking industry dealing with a hazard analysis of the use of forklifts at terminals such as respondent's terminal in Charlotte. She also admitted that, although she reads federal standards interpretations, she was not certain if she was aware of any stating that seat belts must be worn, or advising that federal OSHA will cite the General Duty Clause if it finds operators of forklifts not wearing seat belts.

92. Ms. Murphy testified that it is possible for respondent's truck to pull away from the dock while a forklift is inside the trailer. It is further possible that the forklift could back out of the trailer and fall to the ground. Ms. Murphy classified such an incident as an off-dock incident.

93 The respondent does not provide any training to its forklift drivers regarding how they should jump from a forklift in case of a tip-over or off-dock incident. It provides no agility test or medical procedure to determine if they are capable of jumping from a forklift. It also does not attempt to determine if they could withstand the impact of jumping from a forklift falling off-dock or from the back of a trailer.

94. Ms. Murphy is familiar with the warning labels provided by Toyota on its forklift trucks. One label warns operators to buckle-up. She is also aware that the operator's manual warns of the possibility of tip-over, as does respondent's own training manual. She is also aware that both the American Trucking Association and the Industrial Truck Association were members of the ASME committee which adopted ASME B56.1-1993.

95. Ms. Murphy has never worked as a forklift operator.

96. The undersigned finds the testimony of the complainant's witness and the complainant's exhibits to be more credible and compelling.

97. The penalties were calculated in accordance with the Field Operations Manual.

98. The respondent was not able to show any prejudice to it by complainant's motion to amend Citation 1, Item 1and allege specific hazards in the use of forklifts in that these alleged hazards were generally known to respondent to be the arguable reasons for alleging a violation of the General Duty Clause.

Based on the foregoing stipulated Findings of Fact, the undersigned makes the following

CONCLUSIONS OF LAW

1. The foregoing Findings of Fact are incorporated by reference as Conclusions of Law to the extent necessary to give effect to the provisions of this Order.

2. The respondent is subject to the provisions of the Act.

3. The respondent has violated the provisions of N.C. Gen. Stat. §95-129(1), the General Duty Clause, by failing to require its forklift drivers at its Charlotte terminal to use the seatbelts supplied on their Toyota forklifts during operation. Such violation is a serious violation of the Act.

4. The respondent has violated the provisions of 29 CFR 1910.178(k)(1) for failure to chock the wheels of trailers being loaded or unloaded at its Charlotte terminal. Such violation is a serious violation of the Act.

DISCUSSION

The above Findings of Fact and Conclusions of Law support the result contained in this Order, but they do not fully reveal the mental struggle that occurred in making this decision.

On one side is the complainant, proceeding under the General Duty Clause to hold the respondent accountable for the failure of its forklift drivers to wear seatbelts. In her favor is the weight of technical evidence such as the ANSI standard and the recommendations of the forklift manufacturers. On the other side is the respondent, which daily operates some 5,500 forklifts in some 165 separate locations, with arguably minimal employee safety problems.

Moreover, the forklift drivers seem adamant against using seatbelts, both for perceived safety and for convenience. And, the Act does not, among its thousands of regulations, contain a specific requirement that forklift drivers use seatbelts.

The complainant offered considerable credible evidence that use of the seatbelt, in conjunction with the seatwings and overhead guard, would keep the driver within the guard compartment in the event of a forklift tipover or dropoff. This would prevent the driver from succumbing to the urge to jump from the truck, which has been documented in many cases to be the cause of injury or death to the driver.

While there is evidence to support a decision either way, I believe the evidence presented by the complainant was more compelling. The original research into this issue supports the safety value of seatbelts in these circumstances. The respondent has had prior employee accidents where injury was caused due to tip over or drop off. The respondent did not counter this evidence with organized studies or research. Rather, their evidence was personal experience, statistical or anecdotal. Even the American Trucking Association supported the ANSI standards. To me it is common sensical that, in the event of tipover or dropoff, staying within the guard compartment and holding on is much more likely to reduce injury than trying to jump out. Moreover, within the split second it takes to tip over or drop off, once the condition is recognized by the driver, he very likely has no time to jump clear before impact. The factual circumstances in other cases bear this out.

I am troubled by the fact that the rule-makers have not seen fit to make this seatbelt requirement a specific standard, rather than leaving enforcement to the General Duty Clause. Given the research and history of accidents, it seems that this should have been done.

This circumstance nearly tipped the balance in favor of the respondent. On balance, it appeared that the respondent knows that the seat belt use would be beneficial, but it would appear to lessen efficiency and create enforcement issues with its employees.

As for the wheel chocks, the respondent puts the responsibility for enforcement of this standard in the hands of the person least likely to worry about it -- the tractor trailer driver. If he fails to chock the wheels, he doesn't get hurt. The forklift drivers are the workers at risk. Yet, respondent does not have a program for ensuring that wheel chocks are in place. Surely someone at the terminal is responsible for knowing when a new trailer is backed up to a dock. That person should be responsible for chocking the wheels or for making sure the driver has done so. The failure to do this is manifested by the fact that the compliance officer observed at least five trailers without wheel chocks, some with freight inside.

Based on the foregoing Findings of Fact, Conclusions of Law and Discussion, IT IS ORDERED as follows:

1. The complainant's motion to amend is GRANTED;

2. Citation 1, Item 1, as amended, is affirmed as a serious violation of N.C. Gen. Stat. §95-129(1) with a penalty of $ 2,450.00;

3. Citation 1, Item 2 is affirmed as a serious violation of 29 CFR 1910.178 (k)(1) with a penalty of $2,450.00;

4. Citation 2, Item 1 is affirmed as a nonserious violation of 29 CFR 1910.141 (d)(2)(iv) with no penalty;

5. All penalties shall be paid within twenty (20) days of the date of this Order; and

6. All violations not previously abated shall be immediately abated.

This 29th day of December, 2006.

____

RICHARD M. KOCH
HEARING EXAMINER