OSHI v Cargo Handling Corporation Ltd

2023 IND 15

Cause Number 181/15

In the Industrial Court of Mauritius
(Criminal side)

In the matter of:

OSHI

v.

Cargo Handling Corporation Ltd

Judgment

Accused being an employer is charged under Section 5(1) and Section 94(1) (i) (vi) of the Occupational Safety and Health Act 2005– Act No.28 of 2005 coupled with Section 44(2) of the Interpretation and General Clauses Act with unlawfully failing on or about the 9th of July 2013 to ensure so far as is reasonably practicable, the safety, health and welfare at work of its employees as a result of which one Moutien Jean Claude sustained soft tissue injury to his right leg when a forklift make Hyster bearing serial number D117E01567V toppled forward while he was involved in handling a 20 feet container with the above said forklift at its place of work at Mer Rouge, Port Louis.

The Accused represented by Mr. Doobraj Seegoolam, in his capacity as Assistant Human Resource Manager, pleaded not guilty to the information and was assisted by Counsel.

Mr. M.F. Bhugalee in his capacity as Acting Principal Occupational Safety and Health Officer gave evidence in Court.

He enquired into an accident which occurred at work on 9.7.2013 at the premises of Cargo Handling Corporation Ltd at Mer Rouge where one Jean Claude Moutien, Plant Operator, was using a forklift make Hyster to lift a 20 feet container from a lorry to be stacked in the terminal when at a certain time while the container was being lifted with the spreader, the forklift toppled forward whereby Mr. Moutien sustained soft tissue injury at his right leg as per the medical certificate produced namely Doc. A.

His observations following a site investigation on 16.7.2013 were as follows:

- The accident occurred at the container park of the multipurpose terminal and the forklift involved in the accident was shown by Mr. M. Vincent, Safety and Health Officer and Mr. J.C. Moutien, the injured person.
- The forklift was of make Hyster model H36.00E-16CH and serial number D117E01567V.
- The forklift was designated as FL 35088 with a safe working load of 26 tons.
- There was no system in place in the forklift to indicate to the operator of the weight being lifted.

His enquiry revealed:

- The safe working load of the forklift involved in the accident was 26 tons.
- The weight of the container being handled at the time of the accident was 28.33 tons.
- There was no system in place to indicate to the forklift operator about the weight of the load being handled.

Management views:

A statement was recorded from Mr. Anne Joseph Francois D' Hotman de Villiers on behalf of Management of Cargo Handling Corporation Ltd under warning on 22.1.14 in his capacity as Senior Technical Manager duly authorized by the Director as per Doc. B where he stated that:

- The container to be lifted was of weight 28 tons and the safe working load was 26 tons.

- In reply to the charge that the company failed to ensure the safety and health of its employees by not providing a safe system of work that will indicate to the operator the weight of the container being handled so that the safe working load of the forklift was not exceeded, he stated:
- All Accused's operators received adequate training.
- The stacking of containers on the terminal was segregated by weight.
- All the forklifts were accompanied by a terminal officer who indicated to the operator where to stack the containers.
- Consequently, the operator was fully aware of the type of container being handled.
- In any event, a terminal officer was present to assist the operator in respect to the weight of the container.
- Mr. J.C. Moutien, the injured person, and all operators held a valid licence for forklift and Mr. J.C. Moutien was duly authorized to operate that type of equipment.
- The accident occurred due to the mishandling of the operator as an internal enquiry revealed –
    (a) Mr. J. C. Moutien was employed as Plant Operator by the company.
    (b) The container was being lifted from the lorry with the mast of the forklift tilted outwards.
    (c) In fact, the mast should have been tilted inwards, that is, the tilting cylinder should have been fully retracted.
    (d) The consequence was that the forklift with the container toppled over while being stacked on the yard location.
    (e) The container was of weight 28 tons and the registered machinery inspector namely Mr. Gungaram as per his report dated 26.1.2013, rated the safe working load to be 26 tons. There was an additional 10% safety margin in respect to the safe working load.

After completion of his enquiry, Mr. M.F. Bhugalee drew up a report dated 17.3.2014 as per Doc. C. When he went to the locus of the accident on 16.7.2013, he was accompanied by Mr. I. Rohoman, the Occupational Health and Safety Mechanical Engineer.

According to him, there should have been an indicator inside the forklift indicating to the plant operator of the weight that the forklift was lifting at any time so that he could know what weight he was lifting to prevent the accident although he admitted that he did not have any experience as regards the handling of a forklift as an operator.

He was aware as a Health and Safety Officer that when a forklift was being operated –

(i) it was important to ensure its stability and that the heavier the load, stability became more important;

(ii) when it was lifting a heavy object, the centre of gravity (which is the load centre) should be in the middle. For that kind of operation, there was a level for which the mast or the lifting height of the container should be, the third level on the mast being the highest one depending on the operation.

(iii) It had a spreader which was what was used to lift the containers. The spreader was on the mast which determined the height. The mast could be moved outwards for 30 degrees and inwards for 15 degrees.

He took a statement from Mr. J.C. Moutien but he did not put his version of facts as stated to him in his report and the latter also did not mention that a forklift was allowed to have a 10% additional tolerance for the weight being lifted.

He did not agree that the accident occurred due to the sole mishandling of the forklift by Mr. J.C. Moutien, the operator, which led to the instability for that forklift to topple forward because if there was an indicator inside the forklift, the operator would have known the weight of the container he was lifting. He did not agree that the mast was not fully retracted as it should have been and that the Accused put up a safe system of work which was not respected by Mr. J.C. Moutien.

Mr. I. Rohoman in his capacity as Mechanical Engineer gave evidence in Court. He was registered with the Council of Engineers since the year 2004 and had been working as Mechanical Engineer at the Ministry of Labour and Ministry of Public Infrastructure. In the year 2013, he was posted at the Ministry of Labour as Occupational Safety and Health Engineer in the mechanical engineering department. He had been involved in accident investigation since the year 2000 when he joined the Ministry till to date. He also enquired into the present accident at work in relation

to which he drew up a report dated 11.9.2013 and which included a photograph taken by him on 16.7.2013 as per Doc. D.

He explained the contents of his report as follows:

- From the nameplate of the forklift, it was observed that the machine was designed to be used at a safe working load of 29,400 kg [at 1400 mm load centre] and 26800 kg [at 1610 mm]. However, following a thorough examination of the machine by a registered machinery inspector on 26.1. 2013, the safe working load of the forklift had been reduced to 26,000 kg when the container concerned in the accident as submitted by management weighed 28,330 kg.
- In a forklift, three things were important namely the weight, the load centre and height of the lifting. The machinery inspector had rated the machine for 26 tons and if it was exceeded by 2 tons, it would of course topple if the load centre and height level were not respected.
- If one would go above what the machinery inspector had given, it was going to topple as one would be operating in the dangerous zone of the load chart of that machine.
- There was no digital indicator inside the forklift that would indicate the weight the operator was lifting, the load centre and the height it could be lifted. But what was more important was the weight that was being lifted.
- If the operator could not judge the weight of the container he was lifting and if it exceeded the rated capacity of that forklift, it would topple over. The machine was tested and examined and found to be able to lift 26 tons.
- Had there been a system of work in place so that the operator would have been made aware of the weight of the container being handled by him so that the safe working load of the forklift was not exceeded, the accident would not have occurred.
- He did not agree that for a forklift that could lift between 21 and 50 tons, the actual weight that the forklift could lift was 5 tons above the safe working load as per the ILO guidelines where there was an additional tolerance of 10% above the safe working load depending on range.
- That additional 5 tons above the safe working load meant for the forklift concerned in the accident should come from the manufacturer of the forklift and not ILO guidelines which were only used as a guide.
- When it came to mechanical equipment ILO was just a guideline and could not be relied upon.

- The manufacturer did not carry out an overload test to specify the percentage the machine could be overloaded and it should be in accordance to the manufacturer's specificity and the ILO guidelines.
- That was because of the load centre and the height which that operator was manipulating and the higher he went up, the lower the load he would be able to handle and the more dangerous it was. Then, he admitted that it was a normal practice for the mast to be tilted inwards.
- The forklift was a lifting equipment and by its nature it was a dangerous equipment. If the specifications of weight and height were exceeded, the machine would topple. But the machine would not go outside the range of the height it was designed to go when it was designed for a weight of 26 tons.
- If the operator did not know the weight he was lifting, he was operating dangerously. He agreed that the heavier the load, the closer to the ground it should be lifted to and that it was the basics that in such a forklift when lifting a heavy load, the mast should have been inwards and not outwards. He did not agree that when Mr. J.C. Moutien was handling that load, he did not respect the basics because he was handling weight which he himself he was not aware of the load of it.

Mr. Jean Claude Moutien gave evidence in Court. On 9.7.2013 he was working as forklift operator for the accused company at Mer Rouge and was removing a container from a lorry to be placed down. He had written instructions on a board under his name on that day as regards the machine he had to use and what job he had to do.

Then, he received the assistance of a terminal officer which is a generic term for supervisor, foreman and *"commis"* instructing him from where to lift the containers and where to stack them in the yard so that they were separated according to weight. On the material day, he had already lifted the container from the lorry which had already left and he was in the process of placing it down.

Suddenly, he felt a decrease in level and the machine toppled in front in the yard. He could not say exactly why the forklift toppled in front and he did not know the exact weight that the forklift could lift. On the day of the accident there was no one who told him of the weight of the container he was lifting. In the forklift, the weight of the container he was lifting was not indicated.

However, he had been working for the Accused for 22 years and was still working there. When the accident occurred on 9.7.2013, he had been working for Accused for 13 years and which was quite a long time. He started around the year 2000 as Shuttle Driver till about the year 2007 when he was promoted to plant operator grade 1 and after about one year in May 2008, he was promoted again as plant operator grade 2 which was a superior grade because of his experience for forklift. He had 2 terminal officers working with him giving him instructions namely one telling him where to lift the container from and another telling him where to place it. If there were instructions given on the board to do a work which he could not do, he would have told the Accused about it. He held a licence to operate that forklift at the material time. For the obtention of such a licence, he had to follow training. There were trainings followed by himself and others were provided to him by the accused company. He accepted that he was fully versed as regards training and security advice provided for by the Accused.

He admitted that he knew the weight of the containers he had to lift as they were placed and segregated on the yard according to their weight. But when he had to lift a container from one place, he would not know its weight. On the 9.7.2013, prior to the accident, he had lifted about 5-6 containers and he did not have any problems with them.

It was not for him to decide which container had to be lifted. There was no indicator inside the forklift that would turn on where he exceeded the weight it could lift. But should a container be overweight he would have felt it in the machine with the experience he had as the machine would rise up. He agreed that as per the photograph as per Doc. D, it was the correct way to lift a container as the mast was inclined inwards towards the driver who was the operator of the forklift. The spreader was also inwards.

When the photograph as per Doc. E. was shown to him which was that of the forklift which toppled at the material time, he stated that the mast was on the second level and not the highest level viz. the third one. The mast in the Doc. E. was far from the driver and it was supposed to be with him. The forklift was put to the level 2 as for that container being lifted, he needed to see in front of him where he had to go with the help of the terminal officer to have it stacked.

He was aware of the security aspects concerning the forklift and also security aspects concerning the weight that it could lift. He agreed that although there was a safe working load that could be lifted like where it was 26 tons, there was also a tolerance of 5 tons that could be added in excess meaning a load of 31 tons to be lifted. He did not know exactly whether the safe working load on that forklift was 26 tons. For instance, had the safe working load that could be lifted was 26 tons, then he could have lifted 5 tons in excess meaning a load of 31 tons. He agreed that the higher level the forklift was lifted on the mast, the more unstable it became and at that level 2, the forklift would have become more unstable and he was aware of that. However, he was not aware that he mishandled the forklift while causing it to lift the container at level 2 of the mast which was supposed to be inclined towards the driver meaning operator viz. him and which was not the case.

Mr. D. Ramboruth gave evidence in Court. On 9.7.2013, he was working as Logistics Supervisor for the Accused and he had been working in that capacity for 10 years. He was the one who did the posting for the work on the machines to be carried out by the plant operators. Mr. J.C. Moutien was instructed at about 6.45 to 7.30 a.m. in the morning to work on a forklift found in the container park to lift containers and then he left. There were terminal officers that would assist him afterwards. He was not present at the time of the accident. Plant operators of superior grade 2 operated bigger forklifts dealing with heavier weight containers. He learnt that Mr. J.C. Moutien was injured at its workplace while operating a forklift but he was not present and was not aware at the time of the accident. He did the posting of forklift operators which meant that when there was a volume of work, he posted them on the machines. Then, they reported to the yard location where there was a supervisor and the work was distributed there. In that yard, the containers were separated and stacked according to their weights meaning on one side those that were light were stacked and on the other side those that were heavy were stacked. The forklift operator working in that yard would be able to know whether he was dealing with heavy containers or light ones. The terminal officer who gave him instructions to lift the container would know its weight as he was the one who had to tell the operator where to go to carry out the work of lifting the container as he knew what was its weight. All that information had to be given to the forklift operator by that terminal officer.

The case for the Defence rested on the testimony of Mrs. S. Jowaheer in her capacity as Health and Safety Officer at Accused. She was aware that on 9.7.2013,

Mr. J.C. Moutien, an employee of Accused, was involved in an accident at the container park terminal where a forklift toppled forward. She identified Doc. E. as being the forklift that was driven by Mr. J.C. Moutien at the material time and which toppled forward. According to that photograph, the container was lifted too high of the mast meaning the lifting cylinder. It was probably the third level which was too high level. The container was lifted at too high level of the mast and the higher the container was lifted, the more likely was for the machine to topple. The dark column viz. the cylinder had moved forward, it was not correct as it was supposed to be inwards towards the operator who was the driver namely the injured person. When there was a lifting operation in progress meaning when the container was being lifted, the operator had to get it inwards towards himself and not away from him. If the mast meaning the cylinder was far away, it was more likely to topple forward. It had to be retracted inwards to gain stability on the equipment. If it was not respected, it would cause the centre of gravity meaning the load centre to be shifted and which would cause the toppling to happen. The correct way to lift a container by a forklift would be at the second level so that the operator could see underneath what was going through and the lifting cylinder would be inwards towards the operator so that he had balance on the equipment and the centre of gravity would be maintained and so it would ensure safe operation as was shown as per the photograph in Doc. D.

She was made to understand that Mr. J.C. Moutien had to take the forklift and lift a container from a truck and place it on the ground. There was no need to lift it to the highest level of the mast because it was being placed on the ground meaning not over another container. At that third level, there would be a shifting of the centre of gravity and the more likely was for the toppling to occur.

Mr. J.C. Moutien did receive training as he held a driving licence and the Accused would recruit him and then he would get the job training with the foremen. Mr. Mootien was a superior plant operator in that after having worked for a few years, the Human Resource had found that he was competent to work in that area. The safe working load meaning the lifting capacity of that forklift was 26 tons. There was also a tolerance factor which the equipment could undergo meaning it could go up 10% more from the ILO guidelines.

According to her, the accident happened as the operator did not handle the equipment and the lifting operation with safe lifting techniques. Should the container be too heavy, the operator would have had to do a forceful lifting, he would have encountered difficulties and the rear wheels of the forklift would have been raised.

The correct way to lift a container was as follows:

1. It was a forklift with a spreader and the operator had to place the spreader over the container first.
2. There were 4 corners of the container, once the spreader was landed over the container, it was locked, a clicking sound would he heard by the operator and then only he would start the lifting operation.
3. When he started lifting, the mast would be straight and moved inwards towards himself, retracting it towards himself to gain stability on the equipment and then he would continue the operation.
4. He could carry 31 tons meaning an additional 5 tons if the safe working load was 26 tons.

The operator followed the instructions of the terminal officer given verbally on the yard. There was a safe system of work for handling of containers at the time of accident. There were safety procedures which were followed by operators. She did not agree totally that if there was a load indicator inside the cabin of the forklift, the accident would not have happened.

I have given due consideration to all the evidence put forward before me and the submissions of learned Counsel for the Accused.

It remained unrebutted that the injured person, Mr. J.C. Moutien, had all the training he needed to perform his work as a competent superior grade 2 plant operator of the forklift involved in the accident. He admitted that although the forklift concerned was rated to carry a load of 26 tons, it could carry an additional 5 tons giving 31 tons in line with the additional percentage tolerance afforded by the ILO guidelines and which was still within the safe limit bearing in mind that the weight of the container was 28.33 tons.

He further admitted that he was not aware whether he mishandled the forklift while causing it to lift the container at level 2 of the mast which was supposed to be inclined towards him and not as per the photograph as per Doc. E. Indeed, as per the said photograph as per Doc. E namely the real evidence and as also pointed out by the Defence witness which is in line with the unsworn statement of Accused, he mishandled the machine by not having the mast retracted inwards completely towards him to ensure stability of the equipment. It is clear that in such manner, the centre of gravity would have been shifted meaning the load centre causing instability

of the machine leading to the accident to take place because of the heavy weight of the container but not because the weight of that container had exceeded the safety limit of the forklift which was unknown to him.

Now as stated by the injured person and also conceded by the Defence witness that the level of the lifting on the mast had to be at the second level where the operator could see underneath the container at eye level and whether there were persons down as well for him to follow instructions from. However, I do not agree that had the injured person placed the mast on the third level if need be would have caused the centre of gravity to shift and thus causing the machine to topple forward as a heavy container was being lifted. This is because the forklift was adapted for the third level by virtue of its lifting capacity of a machine of 26 tons with an added safety tolerance of 5 tons as per the ILO guidelines so that the container could not be lifted higher than the third level and had the weight of the container exceeded the safe load capacity of the machine, the superior grade 2 operator would have felt it given the experience he had that it was too heavy as the machine would raise.

It is worthy to note that it was not the contention of the Mechanical Engineer that the level on the mast that caused the machine to topple namely the lifting height. But, I agree that be it at the third or second level, should the mast not be retracted completely towards the driver which means the operator of the forklift, there would be a shifting of the load centre meaning the centre of gravity and that instability would cause that machine to topple forward. Because by virtue of the training received by the plant operators and the valid licence they held including the injured person, they would know when the safe working load of 31 tons, for example, was exceeded inclusive of the added percentage tolerance afforded by the ILO guidelines as they would feel that it was too heavy a load with the experience and training they had as the machine would rise and the lifting height could not possibly exceed the third level designed for the forklift of that capacity as explained by the Mechanical Engineer, Mr. I. Rohoman. Thus, there are adequate safety safeguards as regards the lifting height of the container and the exceeding of the safe working load inclusive of the additional percentage tolerance as per the ILO guidelines catered for by the forklift machine itself. Therefore, it was not imperative for a safe operation of the forklift for the operator to know the weight he was lifting being indicated in the machine or communicated to him in order for him not to exceed the safe working load as he would necessarily know when it was exceeded including the additional ILO percentage tolerance. But the weight of the container was important for the terminal

officers to know for the stacking purposes as the containers were stacked in such a manner that they were separated according to their weight in that container park terminal.

Now true it is that such an additional tolerance load as afforded by the ILO guidelines did not emanate from the manufacturer of the forklift and it was not mentioned in the nameplate of the forklift concerned. Although there was a derating done by an inspector of Accused to 26 tons, that did not include the additional safety tolerance of 5 tons.

Such additional safety tolerance in line with the ILO guidelines had been applied by the Accused as conceded by Mr. J.C. Moutien himself and who was dealing with heavier containers at the container park terminal. So, strictly speaking knowing the weight of the container in this context by the operator prior to the lifting exercise by the forklift would not have made much difference in terms of preventing the accident bearing in mind that there is no dispute as regards the sufficiency of the training dispensed by the accused employer to its employees including the injured person for a safe system of work to prevail at its premises namely at the container park terminal.

For all the reasons given above, it cannot be construed that the accused employer has failed so far as is reasonably practicable to ensure the Safety, Health and Welfare of its employees as averred in the information let alone that the application of the ILO guidelines are meant for providing a methodology for working practices for the purpose of safeguarding and not defeating the safety and health of those category of workers and which have been largely applied in our Labour Legislations.

Thus, I am unable to find that the case for the Prosecution has been proved beyond reasonable doubt. I, accordingly, dismiss the information against the Accused.

S.D. Bonomally (Mrs.) *(Vice President)*
8.3.23