APRIL 1983

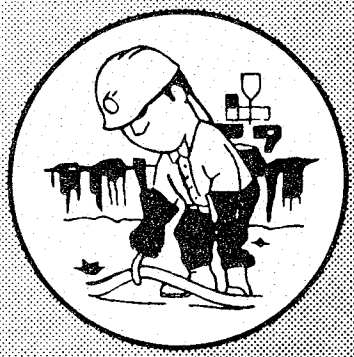
HOLMES SAFETY ASSOCIATION

E PLURIBUS UNUM

SAFETY EFFICIENCY

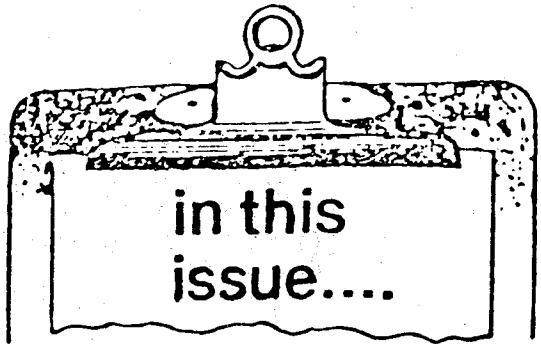
MINERAL INDUSTRIES

BULLETIN



BE ACCIDENT FREE IN "83"

HOLMES SAFETY ASSOCIATION



APRIL 1983

HOLMES SAFETY ASSOCIATION MONTHLY SAFETY TOPIC

April 1983

CSE Loading Facilities
CSE Loading
East Bank, W Virginia

Muncy Mining Co Inc
Yukon Mine
Yukon, W Virginia

J and H Mining Co Inc
No. 6 Mine
Phelps, Kentucky

Hardin & Mapes Coal Corp
No. 7 Mine
Phelps, Kentucky

Mullins & Sons Coal Co
No. 6 Mine
Kimper, W Virginia

Stump Coal Co Inc
No. 7 Mine
Phelps, Kentucky

Mullins & Sons Coal Co
No. 7 Mine
Kimper, Kentucky

Vesta Mining Company
Vesta
McMurray, Pennsylvania

Pocahontas Coal Sales Inc
No. 1 Tipple
Beaver, W Virginia

Pocahontas Coal Sales Inc
Royal No. 7 Mine
Beaver, W Virginia

Pocahontas Coal Sales Inc
Kim-Lyn Tipple
Beaver, W Virginia

Maronatha Coal Co Inc
No. 1 Mine
McCarr, Kentucky

Dotco Energy Co Inc
Dotco Energy
McCarr, Kentucky

Expansion Coal Co Inc
Expansion Coal
McCarr, Kentucky

Stemco Coal Co Inc
Stemco Coal
Ransom, Kentucky

Kentland-Elkhorn Coal Corp
Kentland No. 1
Mouthcard, Kentucky

Kentland-Elkhorn Coal Corp
Kentland No. 2
Mouthcard, Kentucky

Kentland-Elkhorn Coal Corp
Feds Creek Prep Plant
Mouthcard, Kentucky

Kentland-Elkhorn Coal Corp
Feds Creek No. 2 Mine
Mouthcard, Kentucky

Kentland-Elkhorn Coal Corp
Cain Branch Mine
Mouthcard, Kentucky

Deleware Fuel
Mine #2 Shops
Iaeger, W Virginia

Sultan Basin
Tunnel Project
McCook, Illinois

Dixie Clay Company
Dixie Clay-Kaolin
Bath, S Carolina

Four "O" Mining Corp
Four "O" Mine
Grundy, Virginia

Rosebud Mining Company
Rosebud No. 1
Parker, Pennsylvania

Lee Sartin Truck Company
Lee Sartin-Trucking
Naugatuck, W Virginia

Mears Enterprises Inc
Cherry Hill No. 5
Clymer, Pennsylvania

Plateau Corporation
Fairview No. 5 Mine
Punxsutawney, Pennsylvania

Bounty Mining Corp
No. 2 Mine
Grundy, Virginia

Bounty Mining Corp
No. 1 Mine
Grundy, Virginia

Splashdam Smokeless Coal
Splashdam Smokeless
Cedar Bluff, Virginia

Cheyenne Coal Corp
Cheyenne Coal
Wolford, Virginia

Comanche Coal Co Inc
Comanche No. 2
Vansant, Virginia

L and L Energy Co
L and L
Hurley, Virginia

Lick Branch Coal Co Inc
No. 1 Mine
Phelps, Kentucky

Little Duece Coal Co Inc
Little Duece
Phelps, Kentucky

Phelps Mining Inc
No. 3 Mine
Phelps, Kentucky

Apple Branch Mine
Apple Branch
Pikeville, Kentucky

Chapperal
No. 3 Mine
Pikeville, Kentucky

Chapperal
Prep Plant
Pikeville, Kentucky

Continental Enterprises
No. 1-A
Grundy, Virginia

Action Energies Inc
No. 3 Mine
Pikeville, Kentucky

Ka Dee Coal Co Inc
No. 1
Pikeville, Kentucky

Booker Fork Coal Corp
No. 2
Dorton, Kentucky

Anetta Coal Co Inc
No. 1 Mine
Ransom, Kentucky

Arch Coal Co Inc
Arch Coal
Clarksburg, W Virginia

Z & F Development
Z & F
Fairmont, W Virginia

Southern Appalachian Coal
Julian Loadout
Julian, W Virginia

Southern Appalachian Coal
Falling Rock Shop
Julian, W Virginia

Southern Appalachian Coal
Bull Creek Outside Crew
Ashford, W Virginia

Southern Appalachian Coal
Central Shop
Julian, W Virginia

C S and S Coal Corp
C S and S
Grundy, Virginia

Hibbing Area Vo-Tech Inst
Lake Superior-M/NMetal
Hibbing, Minnesota

Michigan Tech University
Experimental Mine/MSHA Trng
Houghton, Michigan

Widows Branch Coal Co
No. 1 Mine
Phelps, Kentucky

Holcomb Energy
Holcomb No. 1
Fenwick, W Virginia

Technology Producers Inc
No. 1 Surface
Marmet, W Virginia

G & M Coals Inc
No. 1 Surface
Layland, W Virginia

River Hurricane Coal Co
Mine No. 1
Kimper, Kentucky

James D Rehe
James D Rehe
Masontown, W Virginia

Toney's Branch Coal Co
Toney's Branch
Bloomingrose, W Virginia

Bill Branch Coal Co Inc
Bill Branch
Vansant, Virginia

Carrie Coal Co Inc
Carrie Coal
Cedar Bluff, Virginia

Carrie Coal Co Inc
Mine No. 4
Cedar Bluff, Virginia

Clinch Valley Coal Corp
Clinch Valley
N Tazewell, Virginia

Reliant Fuel Company
Mine No. 1
Grundy, Virginia

Farwest Coal Co
Mine No. 13
Grundy, Virginia

Solid Fuel Co
Mine No. 3
Grundy, Virginia

Regional Services Institute
E Oregon State MS&H Trng
La Grande, Oregon

HURRY....HURRY.....HURRY!

LAST CALL TO THE

⇩ ⇩ ⇩ ⇩ ⇩ ⇩ ⇩

ANNUAL MEETING OF THE HOLMES SAFETY ASSN., WILL BE HELD AT QUALITY INN/CENTRAL, 1190 COURT–HOUSE ROAD, MAY 24,1983,10am

LODGING, FOOD, DRINKS, MEETING ROOM, ALL AT ONE LOCATION 4 BLOCKS FROM SUBWAY.

THERE WILL BE A HOSPITALITY BAR MONDAY, MAY 23, 1983 7–10 p.m.

NATIONAL SECRETARY

American Mining Congress

1983 COAL CONVENTION

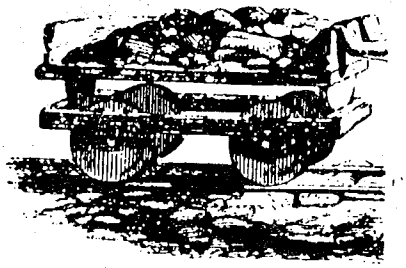
AMC Coal Convention News

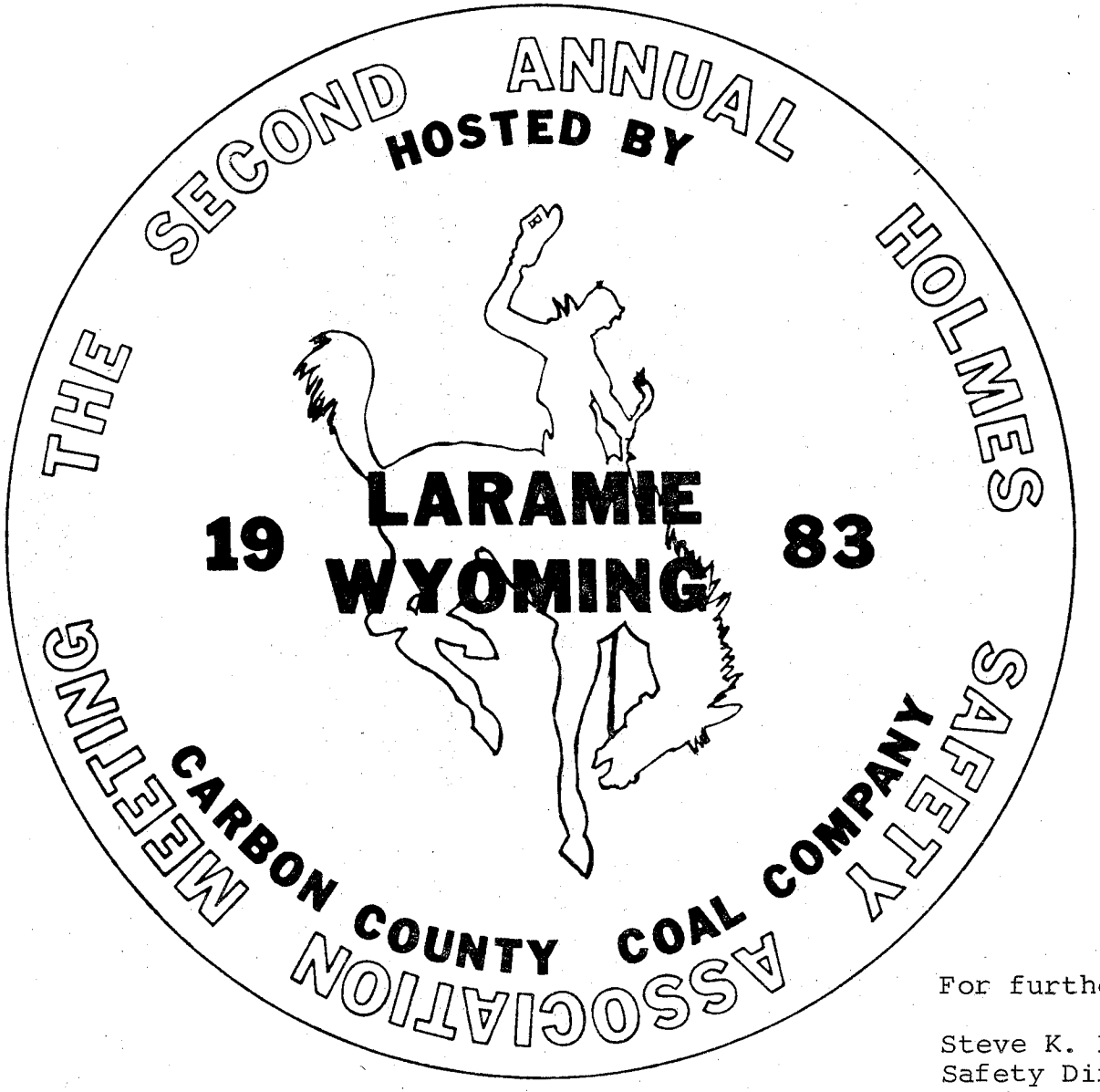
Cervantes Convention Center St. Louis May 15-18, 1983

WELL, IT'S ABOUT TIME WE CAUGHT UP WITH YOU -- AND IN ST. LOUIS, MISSOURI, AT THAT. THE 1983 AMERICAN MINING CONGRESS COAL CONVENTION WILL BE HELD AT THE CERVANTES CONVENTION CENTER, MAY 15-18, 1983.

THE HOLMES SAFETY ASSOCIATION WILL HAVE A DISPLAY BOOTH WITH LOADS OF INFORMATION, PROGRAMS AND POSTERS ABOUT THE ASSOCIATION AND ON MINING SAFETY.

IF YOU ARE PLANNING TO ATTEND AND NEED ADDITIONAL INFORMATION OR RESERVATIONS, CALL THE AMERICAN MINING CONGRESS INFORMATION CENTER 202/861-2834.





For further information contact:

Steve K. Lipe
Safety Director
307/325-9471
Carbon County Coal Company

April 1983

HOLMES SAFETY ASSOCIATION MONTHLY SAFETY TOPIC

Definition of an Accident

Various but related definitions are given for an accident, several of which are recorded here:

1. Webster's Collegiate Dictionary, 1980 edition, defines an accident as follows: "An event that takes place without one's foresight or expectation, especially one of an afflictive or unfortunate character; a chance; contingency; or contingent circumstance." Some synonyms are: "Mishap; mischance; misfortune; disaster; calamity; catastrophe," and so forth.

2. Dr. Walter A. Cutter, Assistant Director, Center for Safety Education, New York University, an eminent national authority on industrial safety, gives the following definition: "An accident is an event. It is unplanned and frequently injurious or damaging. It is an interruption of the efficient completion of any activity. It invariably follows an unsafe act or an unsafe condition."

3. An occupation or work accident may be defined as: "An unintended occurrence arising out of employment that either causes personal injury or property damage; or interferes with production, or other activity, under such circumstances that personal injury might have resulted."

For convenience in discussing why and how accidents occur, the following short definition will suffice: "An accident is an unplanned or unwanted occurrence."

Accident Versus Injury

We will now differentiate between the words accident and injury. The word accident is used rather loosely. It is usually used synonymously with injury. When a report is made of an accident at a mine, often the first question asked is "Who (or how many) were injured or killed?" Mine Safety and Health reports on fatalities and injuries are called "Fatal Accident Report" and "Nonfatal Accident Report." These designations are correct because the injuries and fatalities resulted from accidents; but literally thousands of accidents occur daily in all walks of life, which cause no injury - some cause no damage - nevertheless they are "accidents" in the true sense of the word, because they are unplanned or unwanted. An automobile skids from slippery pavement to the side of the highway and no damage is done to the vehicle and no injury results to the occupants. A shuttle car knocks out a timber without damage, other than the dislodged timber, and with no injury to the operator or anyone else. A fall of roof occurs without hurting anyone. In each of these cases an accident occurred but no injury resulted. It should be kept in mind that an accident

-MORE-

is an unplanned or unwanted occurrence, whereas an injury is defined causing damage or hurt to someone. Some synonyms for injury are, damage, impairment, hurt, wound, and so forth.

It follows, therefore, that many accidents occur without resultant injury, but that injury results only from accidents.

HOLMES SAFETY ASSOCIATION MONTHLY SAFETY TOPIC

"He Used To Be..."

He used to be a real "hurry-wart." First one off the mantrip--first out of the mine. First one out of the plant. First one through the intersection...but there's no rush now. He's got lots of time--an eternity of time.

He used to be a great grumbler. Griped about all the stupid people he worked for. Griped at safety meetings about all the "dull guff" he had to listen to...but there's no grumbling now. He's quiet, real quiet.

He used to be the super-agressive type. Bulled his way through. Pulled disconnects and cut wires without bothering to look or think... but there's no blind motion now. No motion at all.

He used to be full of the nervous fidgets. Jittered all over the job site and in the plant, jittered all through the day...but there's no jittering now. He's calm, real calm, and still.

He used to be the absent-minded kind. Forgot to signal. Forgot to look over the job. Forgot to check his tools and ropes...but there's no forgetting now. No remembering, either.

He used to be the chip-on-the-shoulder type. Had all the answers. No foreman or crew leader could tell him what to do. He'd do it his way...but there's no back-talk now. No talk at all.

He used to be the real dare-devil. Loved to risk his neck. Loved to take the dangerous shortcut. Got a real kick out of taking chances... but there's no chance-taking now. No taking anything, not even a breath.

"He used to be...." A sad story that will be written again and again and again. As long as we don't eliminate our serious faults, there's an excellent chance that they will eliminate us...there's no exaggeration about that now. It's right. It's dead right.

April 1983

HOLMES SAFETY ASSOCIATION MONTHLY SAFETY TOPIC

Beware of Near-Accidents

Think about accidents that almost happened.

Think about those near-accidents, those close-shaves that made you think your number was up.

You've heard soldiers talk of the near-miss when a bomb or shell missed the target, but came so close that it did some damage, or at least gave warning that the enemy had the range. A near-miss was the signal for evasive action-but quick.

Near-accidents don't cause injury or damage equipment, but they do serve notice of trouble and call for some quick action.

A Split-Second Can Make the Difference

Do you know what keeps a near-accident from being a serious accident? It's a split-second of time or a fraction of an inch of space. Is that difference due to luck?

Suppose on your way home you almost run over a child who dashes into the street after a ball. Was it just luck that you swerved and missed him at the last second? No! Another driver might have hit him. Your reflexes may work faster. You may be more cautious. Your car may have better brakes, headlights, and tires. At any rate, it's not luck that keeps a near-accident from being a real one.

A Near-Accident is a Warning

Near-accidents on the job should serve as a warning. A condition that almost causes an accident can easily cause a real accident the next time when you are not as alert, or when your reflexes aren't working as well.

Remember, near-accidents are signs that something is wrong. For example, your piling may be poor, housekeeping sloppy, tools in poor condition, guards not operating correctly. Near-accidents indicate inefficient or unsafe work habits.

So let's keep our eyes open for the little things that go wrong. Let's not just shrug them off as "close ones." Let's do something about them--correct them or report them. Let's treat near-accidents as if they were serious accidents--root out the causes while we have a chance.

ABSTRACT FROM FATAL ACCIDENT

April 1983

HOLMES SAFETY ASSOCIATION
MONTHLY SAFETY TOPIC

MACHINERY ACCIDENT

General Information: An apprentice crusher oiler was fatally injured while attempting to change a grease fitting on a self-cleaning tail pulley. The victim had a little over one month's experience.

Description of Accident: The single bench quarry was drilled and blasted using bulk AN-FO. A D-8 bulldozer then pushed and stock-piled broken material near the portable primary jaw crusher, where a 992 front-end loader was used to feed the crusher. Crushed material was then conveyed to a secondary crushing, sizing, and screening operation, from which it was conveyed to the final product screening plant, where the accident occurred. Finished materials were separated and stockpiled by conveyors according to size. The equipment involved in the accident was a dual, three-deck Pioneer, 5 feet by 16 feet screening plant which received conveyed material from a secondary crushing and screening operation.

The finished rock, minus 1/2 inch, was then moved by a 40-inch conveyor that was located at the bottom of the screening plant feed chute and stockpiled by another conveyor.

The ground around the feed chute at the time of the accident was level and dry. Picking up some grease fittings, the victim mentioned that she was going to change a fitting. This was the last time anyone saw or spoke with her.

About 15 minutes later, the overload locking device on the screening plants was activated. Knowing there was something wrong, the plant operator signaled the labor and plant superintendent, to trouble-shoot and locate the problem. Checking several locations through-out the screening plants, the superintendent saw the victim trapped underneath the finish product plant. He immediately signaled the plant operator to shut down the entire operation.

An examination revealed that the victim died of head injuries and a crushed chest. Evidently, the victim was attempting to change a grease fitting on a self-cleaning tail pulley when her shirt sleeve became entangled in the pulley, which dragged her onto the conveyor and into the pinch point of the screening plant chute lip, causing death. The victim had previously asked a mechanic for grease fittings. During weekly safety meetings, the victim had been cautioned about greasing moving machine parts and, in fact, on several occasions during a work shift, she was observed greasing moving machine parts and stopped by both coworkers and management.

-MORE-

Training consisted of a 2-week indoctrination in which the other oiler worked with her, safety meetings, the plant superintendent giving her instructions, and her working with the plant mechanic repairing breakdowns and servicing equipment.

The conveyor-tail pulley, which caused the accident, was an integral part of the screening plant. It was located under the screen operation and was difficult to get to because crossed pieces of angle iron mounted in the frame of the screening plant blocked the entrance on both sides. Because it was low to ground level, a person had to crawl or stoop when entering; therefore, moving parts could not be contacted unless extra effort was made.

Cause of Accident: The direct cause was the victim doing work on a tail pulley grease fitting while the plant was operating.

A major contributing factor was the victim's failure to follow work procedures.

Recommendations: Compliance with the following recommendations should prevent recurrence of similar accidents.

56.14-35 (M)	Machinery shall not be lubricated while in motion where a hazard exists, unless equipped with extended fittings or cups.
56.14-29 (M)	Repairs or maintenance shall not be performed on machinery until the power is off and the machinery is blocked against motion, except where machinery motion is necessary to make adjustments.
56.18-5	All employees and officials should be familiar with company, State, and Federal health and safety regulations applicable to their jobs.
56.18-11	All supervisors and employees should be trained in accident prevention.
60.18	Instructions to all employees should be accurately stated and made perfectly understood.

Conclusion: It is the responsibility of management and supervisors to see that the above recommendations are complied with.

April 1983

HOLMES SAFETY ASSOCIATION MONTHLY SAFETY TOPIC

When Safety Rules Are Ignored

Each of us at some time has felt that a safety rule is just too much trouble. A few people, it is said, even feel this way quite often! Making the safety effort seems like too much of a bother when the odds are against getting hurt anyway.

The trouble with this type of thinking is that the odds really aren't that good. Maybe the chances of getting hurt on a certain job are only one in a thousand. But no one can tell whether that fatal time will be 999th, the 49th, 13th, the 3rd, or the 1st.

And then, even if the little extra effort for careful working takes time, it's better than viewing the world from a hospital bed.

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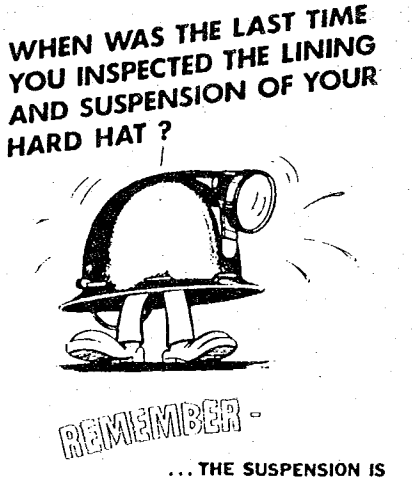
YOU CAN SEE / HEAR / SMELL / FEEL SOMETHING'S WRONG

While most accidents are caused by the mistakes of people, a few involve failures of equipment. But even these mechanical failures can be traced back to someone's mistake, such as not being alert to defects in equipment and not reporting them.

Your senses can help you spot something wrong--
SIGHT: Be on the look-out for accidents in the making.
HEARING: Listen for the off-beat sounds of defective or improperly adjusted equipment.
SMELL: Your nose can help you detect most gas or chemical leaks, overheated bearings, burning brakes, arcing electricity.
TOUCH: Your hands can warn you of such things as excessive vibration or overheating.
AND for good measure, there's your common sense!



April 1983

HOLMES SAFETY ASSOCIATION MONTHLY SAFETY TOPIC

Any supervisor knows that accidents must be investigated to get the information required under state law, perhaps for the insurance company, perhaps for facts required in case of a legal dispute.

But the experienced supervisor knows that every accident investigation should also show how to prevent another such accident. Each detail should be investigated fully to know what caused the accident; whether it was a physical condition or if someone committed an unsafe act. The inspection should be done promptly because conditions may change quickly and details be forgotten. Check the facts from every possible angle and get every person's version of the story.

Supervisors should also realize that the investigation alone is not sufficient. A committee of workers or a labor-management committee with a safety engineer not directly involved can bring to light many new facts and the supervisor should talk with all the people. The conclusions of the investigators will show how to avoid the same accident. Corrective action may involve repairs to equipment, reorganizing work, or giving a different kind of training.

An accident--says the dictionary--is an unexpected or unforeseen event. According to that definition you probably have many accidents each day, although only a few of them result in injuries. For example, a wrench falls from a platform. It doesn't hit anyone, but how do you know that it won't next time? If you do your job right you're going to investigate that falling wrench just as if it had caused an injury. Find out who dropped it and why. Should there be a tool rack attached to the platform? Is the rack inconvenient? Train yourself to think of every unexpected event that happens in your department as something that might have caused an injury, and take steps to prevent its happening again. The difference between an unexpected event and an accident--sometimes a fatality--is often chance.

Do You Learn A Lesson From An Accident?

ABSTRACT FROM FATAL ACCIDENT

April 1983

HOLMES SAFETY ASSOCIATION
MONTHLY SAFETY TOPIC

MACHINERY ACCIDENT

General Information: A fatality occurred when a mechanic, for some unknown reason positioned himself between the machine and the mine roof by leaning over top of the machine. The victim's head was crushed between the top of the stabilizing jack and the mine roof.

Description of Accident: On this day, the roof bolting machine was leaking oil badly. The mechanic proceeded to the area of the roof bolting machine, and the supervisor went to move the cutting machine into postion to start preparing coal.

While doing so the machine became stuck on the mine floor and he had to utilize the maneuvering jacks to get the machine into the place, which caused a delay. As he was maneuvering the machine to free it, he observed flashes from the mechanic's cap light and heard roof bolting machine sounds that appeared to be normal operations.

After getting the machine into position he traveled to the explosive magazine and loaded explosives on the shooting buggy. While doingthis, he noticed the roof bolting machine sounds had changed and suspected something was wrong. He traveled into the entry and could see the mechanic's cap light shining against the roof.

When he got to the roof bolting machine, he saw the victim's head between the stablizing jack and the mine roof. He deenergized the machine and got the victim by the shoulder and pulled him from on top of the machine. There was no pressure against the victim's head and he was easily removed from the machine. There were no signs of life.

Discussion: The emergency deenergization device installed on the Galis 300 roof bolting machine was not adequate. It did not extend a sufficient distance to permit quick deenergization of the tramming motors from all locations from which the machine could be operated. This deenergization device was designed in a manner that when the tramming motors were deenergized, the pump motor, which controls the hydraulic system was deenergized also.

A co-owner stated the roof bolting machine could not be maneuvered properly when the hydraulic oil level was low. He also stated in his opinion, the victim's intention was to roof bolt the place before bringing the machine into an area where the roof was higher in order

-MORE-

to make repairs and replenish the oil level in the machine. He said in order for roof bolts to be installed when the oil level in the machine was low, the bolts had to be installed out of sequence by tramming the machine forward for the first line of bolts, then backing the machine out of the place and tramming the machine forward again for the next line of bolts.

The approved roof control plan was not being complied with at the time of the accident. The four (4) roof bolts that had been installed in the place were not installed in the sequence as required by the approved roof control plan.

Evidently, the hydraulic oil became so low the machine was unable to adequately tram forward and the victim attempted to locate the oil leak by leaning over top of the machine.

While in this postion, his body came in contact with the lever which raised the boom on the machine. When the boom raised, it caught the victim between the machine and the mine roof.

In order to free himself, the victim reversed the lever and when the boom came down to the mine floor, the machine was rapidly raised, catching the victim's head between the mine roof and the top of the machine.

Cause of accident: Roof bolts were being installed in a sequence which was not acceptable by the approved roof control plan - - A violation of Section 75.200, 30 CFR.

The emergency deenergization device, provided on the roof bolting machine to quickly deenergize the tramming motors in the event of an emergency, was not sufficient. It did not cover all areas from which the machine could be operated - - A violation of Section 75.523-1, 30 CFR.

Conclusion: The accident occurred because the victim failed to recognize a hazard existed and placed himself in a confined space on top of energized mining equipment.

A contributing factor was the absence of an adequate emergency deenergization device on the roof bolting machine.

April 1983

HOLMES SAFETY ASSOCIATION MONTHLY SAFETY TOPIC

We Cannot Assume Safety

Every time we assume something, we are taking a chance until we check it.

We assume the sprinkler valve is open; we may be in for a disastrous surprise unless we check it periodically.

Assuming a dull tool is good enough for a job, assuming an electric tool is grounded--both are assumptions with hazards.

We assume this mushroomed chisel won't chip this time so we assume we won't need our safety glasses, but we know we can't see with a glass eye.

I assume falling objects won't drop on my foot today so I won't wear safety shoes today, but the X-ray shows a fracture of the distal phalange of the left great toe.

Every time we assume something for safety, assume your assumption can be wrong.

HOLMES SAFETY ASSOCIATION MONTHLY SAFETY TOPIC

How Heavy?

One question that repeats itself is: "Is there a pound limit on how much a person can lift safely?"

There are many factors other than actual weight that cause injuries when lifting. Poor posture, sudden exertion, twisting movements and slipping are a few such causes.

There are no hard and fast numbers in pounds on what is safe to lift. It depends on the person and circumstances.

How much we can lift varies with the person and often with the person's condition at the time. Cargo handlers develop judgment and know their own capabilities.

They know they cannot equal a trained weight lifter in a one time lift, but they can and do handle pieces that ordinary persons who are out of condition would have no business touching. They learn to judge the weight of a piece before trying to lift it, to get a secure grip, make sure of a firm footing, and above all, get help if in their opinion it is too heavy for solo lifting.

April 1983

HOLMES SAFETY ASSOCIATION MONTHLY SAFETY TOPIC

WOMEN IN MINING

Proper Fitting Clothing and Equipment

One of the problems women face in entering an occupation, such as mining, which has been almost exclusively male, is in obtaining properly-fitting clothing and equipment. This is not only awkward and uncomfortable but can be dangerous as well.

According to a study conducted by the Coal Employment Project, problems exist in the following areas:

Boots--There is not widespread manufacture of steel-toed boots for women. Consequently, many women buy and wear men's boots that do not fit properly. This can cause a lack of secure footing resulting in trips and falls and ankle injuries. Many women wear extra pairs of socks and blisters and callouses often result.

Hard Hats--Since many women are wearing hard hats designed for men, there are problems in securing a tight fit. Women have resorted to stuffing the inside of the hat to take up the extra space. Some women have made ties to go under the chin to hold the hat on. Some have even resorted to cutting the liner band and taping it back together to make it smaller. Loose-fitting hard hats are distracting to the wearer and can be a safety hazard.

Work Gloves--Men's gloves are usually too big for women. Some have to remove the glove to perform specific tasks. Besides being awkward, a glove that is too large can easily be caught in moving machinery. This can result in serious injury to fingers, hands and arms.

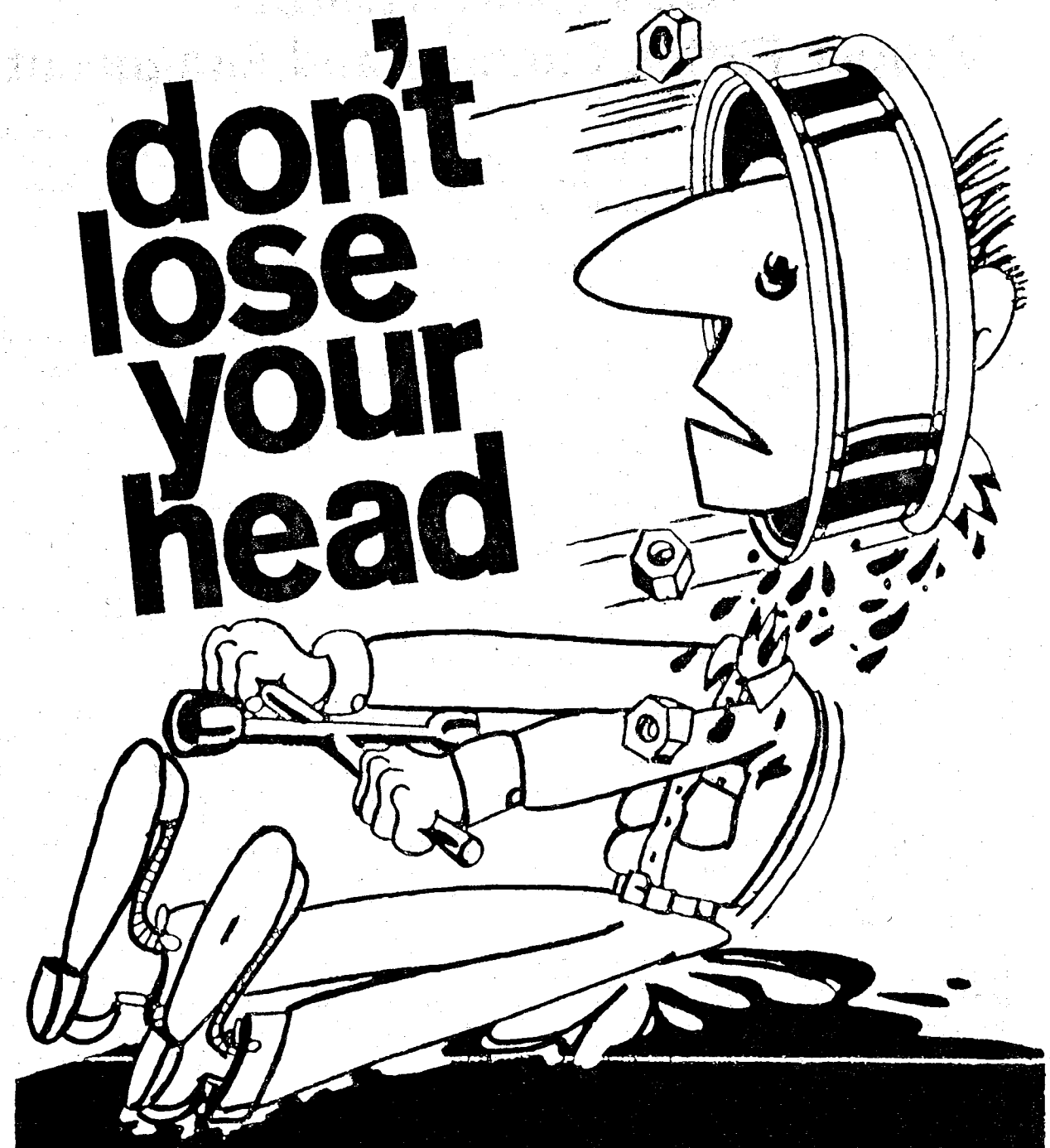
Ear Plugs--Wearing of ear plugs that are too large causes irritation of the ear canal and headaches. In a noisy mine environment, working without ear plugs can result in ringing of the ears and/or a temporary hearing loss.

Respirators and Self-Rescuers--Respirators and self-rescuers that are designed to fit larger facial structures leave gaps when worn on smaller persons, reducing the effectiveness of the equipment. This is important in the case of respirators, it is critical in the case of self-rescuers.

The Coal Employment Project concludes that the mine environment is too dangerous to be using "makeshift" equipment in. Companies should make every effort to provide adequate protective equipment for all its miners.

HOLMES SAFETY ASSOCIATION MONTHLY SAFETY TOPIC

don't lose your head



...when working on wheels or rims.

April 1983

HOLMES SAFETY ASSOCIATION MONTHLY SAFETY TOPIC

Sell Yourself Safety

There are many ways that management and safety committees try to put the idea of safety across and it may be that each one plays a part in the ultimate realization.

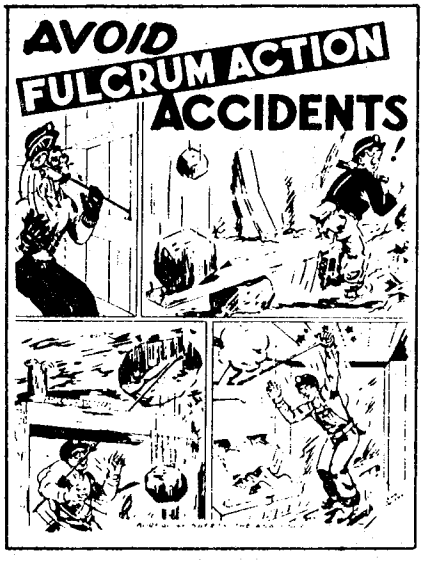
Can you do it with slogans? Definitely not, is the opinion of those who have made a study of it. Slogans are fine, up to a point. They serve to remind that doing a job the unsafe way can maim, or kill, and bring untold suffering to workers and their families. But slogans are at best just an aid.

How about bulletins and literature about safety? Like the slogans, they help remind the worker about the rewards and penalties of safe and unsafe working habits but their effectiveness is definitely limited.

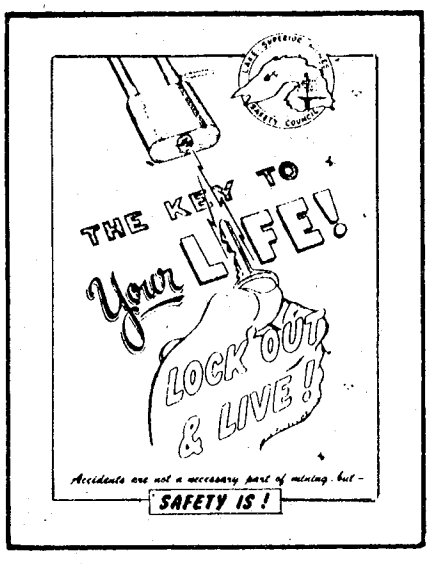
How about disciplining the careless worker? Sometimes effective, sometimes not, they say. It depends on the individual.

There are few times that safety can be preached to a receptive audience. One of these is immediately after a bad accident. While the details of an accident are still fresh in the employees' minds, they are very safety conscious.

All of these suggestions are effective to a certain degree, but in the final analysis it is pretty well agreed that the answer lies not in slogans, disciplining, better equipment, or safety literature. It all comes down to the fact that it is still up to the individual to accept safety responsibility--consistently. Not just today, or tomorrow or all of next week. But every day of the year, every day of our career. Every person must be their own safety supervisor. Management can help make conditions safer, provide the safest equipment and tools; but, it's still up to the individual whether or not an accident occurs.



Lock Out and Live!



April 1983

HOLMES SAFETY ASSOCIATION MONTHLY SAFETY TOPIC

How to Lift

When it comes to lifting objects,
  Whether heavy ones or light
You must always be quite certain
  That it's done exactly right;
For you never make a movement
  Without muscles being tense,
And to keep them lined up properly
  Is all that makes good sense.

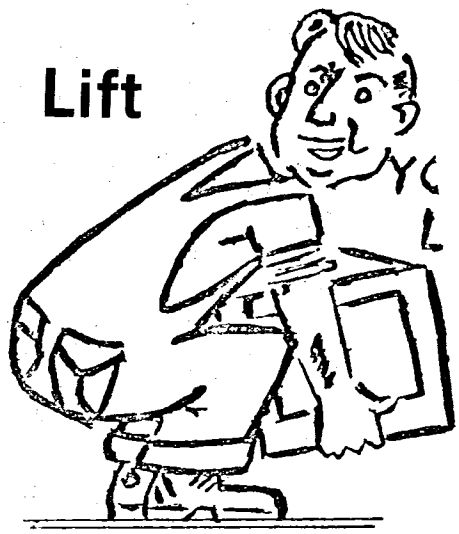
Now, your back is made of muscles
  That are flat and wide -- but thin,
And they mustn't pull at angles
  Or they'll really hurt like sin.
So you keep your back as upright
  As a soldier on parade,
And you let your legs do all the work,
  Because that's how they're made.

Your legs, you see, are round and thick,
  With muscles shaped the same,
So they will do the heavy work
  And never wind up lame.
You merely squat to grasp the load
  and keep your back up straight;
You lift by standing upright
  and your legs take all the weight.

But remember, when you're lifting,
  That the best thing you can do
Is examine what you're lifting
  And think the whole thing through,
So you don't find out it's heavy
  When it's halfway in the air,
Or you need some good assistance --
  But it simply isn't there.

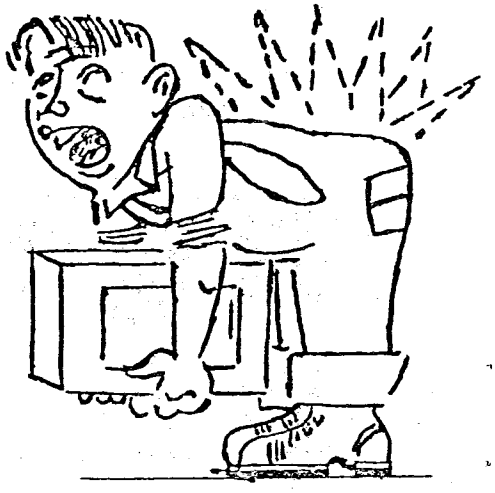
So, you look it over closely
  And decide before you start
Whether more than your capacity
  Is sitting on that cart.
And if it is too heavy,
  Or too bulky for just you,
Why, get a hoist! Or get some help!
  Be healthy when you're through!

Lift



with your legs

not with your back



April 1983

HOLMES SAFETY ASSOCIATION MONTHLY SAFETY TOPIC

Shock The Killer

Ironically, the purpose of shock is to defend the body against life-draining injuries. In most injuries and especially in those where blood or other body fluids are escaping, the body senses its peril and acts quickly to keep itself functioning. It does this by constricting the network of tiny vessels that supply blood to outlying areas, including the skin. Hampered by smaller openings, the vessels cannot transport the usual volume of blood and the skin becomes pale, indicating the first sign of shock.

Excess blood, drained from the extremities, then goes where it is most needed--to the body center. There, it cannot ooze out from the body and can feed vital organs, the heart, kidneys, and liver that must be kept operating at all costs.

The body lifesaving scheme seems sensible; however, it soon backfires. Outer tissues, especially the brain, begin to feel the pinch and demand their share of blood through tiny vessel openings. Everything in the body begins running at an abnormally fast pace. The circulatory system is highly disturbed and out of balance. Finally, like an exhausted athlete who tried hard, but lost the race, the body simply collapses in deep shock.

Tight blood vessels suddenly relax and stretch like old rubber tubing. Blood that once raced through tiny holes, now flows sluggishly, only partially filling oversized vessels. Blood pressure drops drastically. Tissues get less oxygenated blood than before. Still, the faithful heart increases its frantic efforts to pump blood rapidly through the body. But it is a lost cause, for the tissues slowly starve from lack of oxygen. And as vital organs die, so does the whole body.

First Aid Steps

Death from shock can occur several minutes, several hours or several days after injury. Once shock reaches advanced stages, it is difficult to combat, although physicians can save some victims by plasma and use of certain drugs that constrict the blood vessels. The heartening aspect of shock is that it need not become advanced. Immediate first aid can halt its progress.

Any person with a substantial injury is apt to develop shock. Every injured person should be immediately treated for shock, even though there are none of the symptoms of pallor, rapid heart beat, shallow breathing or a dazed expression. The purpose of emergency treatment is twofold: Prevent shock and stop its progress.

-MORE-

Combating shock is a simple thing to do. First, place the victim in a lying down position. Then reverse what you see in the victim. He seems cold, so maintain body heat by a cover to keep him comfortably warm. His face is pale, so lift his feet (if this does not interfere with an injury) to send blood flowing to the head. Should he be conscious and able to swallow, let him sip small amounts of water. Keep him lying down for in this position the body is able to stabilize circulation. Unless he is in imminent danger from a burning building, or such, do not move him. Secure medical help and assistance. A firm hand grip and comforting words are excellent therapy for shock.

These procedures may seem appallingly simple for fighting shock,but they are effective and have saved more than one person from death.

HOLMES SAFETY ASSOCIATION MONTHLY SAFETY TOPIC

The Safety Process

Knowing that the safety process is a fundamental behavior pattern, namely that of self-preservation, we then ask ourselves, "What constitutes a safety process?"

A safety process may be divided into five key factors or variables, namely:

1. The human factor--the person performing the work.

2. The machine factor--the tools or equipment used in doing the work.

3. The material factor--the substances upon which the work is performed.

4. The procedure factor--the method by which the work is performed.

5. The environmental factor--the area and conditions under which the work is performed.

The degree to which the individual factors affect the overall safety process may vary from one application to another. Also, these factors need not necessarily be independent of each other, nor need they be fixed assessments for any one particular safety process.

For proper evaluation, each factor is subdivided into a number of importantly related categories which in turn can be broken down into specific details depending upon the nature of the process. Each listing should not be considered complete but should indicate generally the scope of the factor under evaluation.

April 1983

HOLMES SAFETY ASSOCIATION MONTHLY SAFETY TOPIC

What Is A Tailgater?

Somewhere between the fume-spouting exhaust pipe of the tractor-trailer and the dainty white puff from the Volkswagen, we find a delightful creature known as a tailgater.

Tailgaters come in assorted sizes and shapes--mostly repulsive. You find them everywhere--but mostly two feet from your rear bumper. Undertakers love them, the driver in front hates them, policemen tolerate them, empty highways frustrate them, nobody can ignore them, and God only knows who protects them.

A tailgater is ignorance with a weapon at its command...death with a gleam in its eye... stupidity with the power to kill...and irresponsibility with a driver's license.

A tailgater has the appetite of Dracula, the energy of a 400-horsepower engine, the curiosity of an inspector of rear bumpers, the lungs of a stuck automobile horn, the enthusiasm of a horseman chasing Lady Godiva, and the shyness of a fullback three yards from the goal line.

No one else is so familiar with the hospital emergency room or so at home in traffic court. When you're stranded on an empty highway, he roars past with a wave. When you don't want him, he's grinning at you in your rear-view mirror. No one else can cram into 20 years of driving four smashed Fords, five smashed Chevies, six smashed Plymouths, two smashed Cadillacs, and one Barracuda knocked off a bridge into the river.

A tailgater is a fabulous creature. You can keep him out of your back seat, but you can't keep him out of the wreckage of your trunk. You can charge him higher insurance premiums, but you can't charge him with the murder of his victims. You can suspend his license, but you can't suspend his driving. He's your terror, your shadow, the cause of your cursing, and your constant companion on the road. But when he finally turns off at a tavern, he's a soothing vacant space behind your car, a toothache that has stopped hurting, a feeling of safety in the world.

And when he breaks your neck in a rear-end collision and comes to visit you while you're in traction, he can bring tears to your eyes with these apologetic words: "I don't have any insurance, you know."

THE LAST WORD

MSHA DATA SHOW 1982 COAL FATALITY DROP

Preliminary data from the Mine Safety and Health Administration indicate a sharp reduction in the number of coal mine accident deaths for 1982.

MSHA said the number of fatal accidents in coal mining decreased last year to 122, down 31 deaths or 20 percent from 1981. The preliminary data indicate that 83 coal miners died in accidents at underground mines and 39 were killed at surface mines or facilities.

The leading cause of death was roof falls, followed by injuries involving haulage vehicles and machinery-related accidents.

MSHA Director Ford B. Ford said the reductions were a "positive sign" and that the government found the "sharp decreases truly encouraging. I know that an increasingly cooperative spirit and improved safety awareness on the part of everyone--the mine operators, miners and state and federal mine safety agencies-must be given significant credit for these reductions," Ford said.

APRIL

The Latin word for April comes from one meaning "to open," and true to its name the month opens the gates that summer may enter. The variable weather of its 30 days, with sudden showers and sunshine, has given an added meaning and April is sometimes a synonym of fickleness.

On the first day of the month of April, if you pick up a bundle or a purse from the sidewalk, you may find it worthless and be called an "April fool." In France, where such practices have been the custom since the 16th century the victim is called an "April fish." The custom of playing tricks on this day is so old that its origin has been lost. India from time immemorial has had its spring festival of Huli, ending March 31, in which tricks and pranks play a large part.

Horseplay, tricks and pranks on the job can lead to an injury either to ourselves or to our co-workers. The victim then would be an "April fish.

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DON'T BE AN APRIL FOOL -

THINK AND WORK SAFELY

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